A PASTORAL RESPONSE TO DEPENDENCY ON PRESCRIBED DRUGS IN WOMEN

A Dissertation

Presented to

the Faculty of the

School of Theology at Claremont

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

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by

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May 1983

This dissertation, written by

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ACKNOWLEDGEMENTS

This dissertation is not a detached objectivated study. It is rather, an expression of who I am, or more specifically, who I have become in the process of researching and writing it. Now that it is completed I am struck by the extent to which the influence of many people has helped to shape my feelings, concerns and insights. To all of these I am grateful but in particular I wish to offer thanks to the members of my advisory committee, Howard Clinebell, Allan Moore, Daniel Rhoades, and Father Patrick Thompson, all of whom have been both supportive and challenging. I am especially grateful to Charlotte Ellen whose courageous and dedicated feminism has been an inspiration and a model for me. I thank too Reverend James Rhoades, Chaplain and Counselor in Pomona Valley Community Hospital for his cooperation and help in my practical research. The seven women who entrusted their stories to me are owed a special thanks for their trust and candor and for the time they dedicated to recounting their experience. I received encouragement and support from the pastors and people of St. Margaret Mary Parish, Lomita. For that I am grateful, but even more I cherish the experience they gave me of the love and the power generated by a living and growing community of faith.

To my primary religious community, The Sisters of St. Louis I offer thanks for the spiritual, emotional and financial support which made it possible for me to give time and energy to this undertaking. Finally, my gratitude is offered to Mrs. Beth Boyer for the dedicated hours spent in typing the several drafts of this dissertation, a service which she offered and carried out with incomparable patience and cheerfulness.

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ABSTRACT

This dissertation draws from the stories of seven women recovering from dependency on prescribed drugs, from current literature on chemical dependency in women, from contemporary Catholic theological anthropology, and from feminist analyses of woman's situation to formulate an understanding of the problem upon which a proposed response is based.

The understanding of the problem has a dual focus. First, dependency on prescribed drugs is seen as a symptomatic reaction to religio-socio-cultural conditions which form an oppressive milieu for women. Secondly, it is seen as a problem which, once set in motion, has its own autonomous dynamics regardless of the causes. These dynamics are embodied in three progressive stages: normal use of the drug/s, dependent abuse of the drug/s, and confused, despairing abuse of the drug/s.

The proposed response is three-fold. First, it calls for a change of consciousness and a corresponding change in attitudes and policy regarding women on the part of the Church. Second, as a preventative measure, it requires a ministery which is more in tune with the experience and needs of women so that the Church may become a more nurturing

environment for woman's transcending growth. Third, in the case of those who have become afflicted by drug dependency, it necessitates a ministry which is well informed on the nature of the problem and which brings both the secular resources of the community and the spiritual resources of the Church to bear upon it.

The aim of the dissertation is to formulate a response which relates specifically to the pastoral ministry of the Roman Catholic Church in the United States where long-term counseling is not a vehicle of ministry. Rather, the preferred mode of pastoral care is that which takes place within existing but expanded forms of ministry; prayer, sacraments, preaching, education and administration.

INTRODUCTION

In The Female Fix, one of the few books written on the topic of medication addiction in women, Muriel Nellis states that for women, legal drug or alcohol abuse has become "a common hazard that threatens one out of every four of us." In 1978 the acting director of the National Institute on Drug Abuse told the House Select Committee on Narcotics Abuse and Control that, in the past year, a total of sixty-four million women had used tranquilizers, sedatives, and stimulants in the form of diet pills.[1] It is highly unlikely that in the years since, the number of women drug-users has diminished. It is apparent, that for many women, drugs have become the major means of coping with the greater and lesser pains of life. Such a state of affairs should be a matter of concern for the pastoral counselor, minister, priest, rabbi, and for the Church community as a whole.

First, it is a truism that the very drugs which have become the major means of alleviating painful physical, psychological, and spiritual symptoms often become the source of further symptoms, for the alleviation of which a further, and often increased dose of the drug is either self-prescribed

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[1]Muriel Nellis, The Female Fix (New York: Penguin Books, 1980), p. 1.

or prescribed by an unwary or careless physician. The Church professes concern over the quality of life. It cannot remain faithful to its mission to promote life in its fulness and remain ignorant of, or unconcerned about, the deterioration of the quality of the lives of these women, and the consequences for the lives of their spouses, families, and friends.

In this dissertation I will discuss the problem from two perspectives. First I will consider the phenomenon of dependency on prescribed drugs in women in terms of what it says to the Church. My reading of the literature in the area of drug-dependency in women and my understanding of the experience of women who have become dependent on prescribed drugs indicates that women use prescribed drugs to a large extent to cope with life-problems. Coping is a response designed to deal with a situation without changing it. It is a form of adjustment. Women who "cope" are responding as best they can to conditions arising mainly from the inferior status and the cultural oppression of women. The presence of women in the Catholic church who are dependent on prescription drugs speaks to the church of the oppression of women. In this sense it is a symptom of a situation which affects not only the women who are drug-dependent, but also all women. It therefore calls the church to acknowledge this evil, to own its part in it, and to take steps first towards its own reformation, and then towards the reformation

of society in regard to equality and justice for women. Secondly, I will discuss the problem as a disease which affects the whole person as well as her family and close associates and suggest ways in which the healing ministry of the church may be directed towards her.

Coping as a permanent response to life is a mode which is contrary to the nature of human persons as described in Chapter 1. The human person, by right of being human, is openness towards the transcendent, to a mode of personhood rooted in but always beyond present experience. The predominate mode of personhood should be growth in dialogue with the world of persons, events, and things. However, this relational mode requires a relationship of equality between persons, one which is not frequently experienced by women. If the church is to be genuinely concerned about the abuse of drugs by women, it must also be concerned about conditions which make coping not just a response to crises, but a way of life for many women.

In Chapter 1 I explain what it means to be human according to Catholic anthropological theology, and I point out cultural obstacles to the acknowledgement of and the realization of that humanness in women. I also delineate what needs to be done within the church so that it may progress towards equality and justice for women.

In Chapter 2 I present the stories of women who have used drugs to cope with physical and emotional problems to the point where the drugs themselves became destructive. I examine these stories and abstract from them a profile of the drug-dependent middle aged woman and the process of this disease as it affects her.

In Chapter 3 I discuss the characteristics of the drugs commonly prescribed for women and their hazards. I also discuss the milieu in which drug-dependency takes place as the underlying ground of dependency, and explore characteristics of women who become dependent on prescribed drugs.

Chapter 4 discusses theological issues related to the inferior status of women. Issues such as inadequate notions of suffering, sin and hope affect woman's growth in personhood and underlie the basic mode of coping in women, of which drug-dependency is a particularly destructive form.

Chapter 5 presents a model for a response to the underlying conditions in which prescription drug-dependency flourishes and a model for ministry to the drug-dependent woman in the Catholic parish community.

Chapter 1

A THEOLOGY OF PERSONHOOD

Any attempt to grapple with problems in a way which will have impact on the conduct of human life presupposes either an implicit or explicit theory of what it means to be human. A difficulty with implicit theories is that because they are largely unarticulated and preconscious, they tend to be inaccessible to the modifying and corrective influence of life as it is lived, and as it is reflected upon through the perspective of the human sciences. Furthermore, the normative values of such theories are not too readily available as touchstones against which to test the quality of life as it is experienced. It seems important, therefore, at the beginning of this investigation of the problem of dependency on prescribed drugs, a problem which affects the quality of human life, to delineate an explicit theory of human existence.

Because the ultimate aim of this dissertation is to formulate a pastoral response to the problem, this theory of human existence should not be merely humanistic, but also theological. Moreover, because I am Roman Catholic and because one practical aim of my efforts is to influence the mode of pastoral care and counseling within the Catholic Church, the

point of departure in formulating a foundational theological anthropology will be the reflections of two major Catholic theologians, Karl Rahner and Edward Schillebeeckx. I will discuss the strengths of theological transcendent anthropology in regard to pastoral care and counseling. I will then indicate its weakness in regard to women. Finally, I will discuss the use of story as a method of doing research and its relationship to the theological foundations of this dissertation.

Karl Rahner's Theology of Human Existence

The core of Rahner's theology of human existence is contained in his book, Nature and Grace. First, Rahner discusses the traditional view of nature as "what we experience of ourselves without revelation;" and grace as a "superstructure above man's (sic) conscious spiritual and moral life."[1] He then goes on to question the adequacy of this notion of nature and grace, and ends with the argument that grace penetrates not only our essence but also our existence. Rahner credits to this suffusion of our existence by grace the possibility of making an existential decision, i.e., of doing a morally good act. For Rahner, one's entire spiritual

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[1]Karl Rahner, Nature and Grace (New York: Sheed and Ward, 1963), p. 116.

existence is permeated by grace[2] which places us in the transcendent order of salvation. Whereas it is possible to have "primitive nature" (untouched by grace), in fact, human nature is always "nature in a supernatural order . . ." The definition of created spirit is "openness to infinite being." True, we cannot make grace the object of knowledge by introspection, nevertheless, God's active presence is going on in the conscious sphere of our lives without one necessarily having reflective access to it. What Rahner calls "this supernatural apriori of our spiritual existence" can only be brought into consciousness by revelation coming from without.[3]

> When man (sic) is called by the message of a faith of the visible Church, this call does not come to a man who is brought by it (and by his conceptual knowledge) for the first time into contact with the reality it proclaimed; but it is a call which makes him reflect on and realize (and of course makes him take up a position towards) what was before the unrealized but truly existing grace present in him as an element of his spiritual existence.4

Grace is then the "very sphere of existence" of all persons, believer and unbeliever, alike.

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[2]Rahner defines grace as God's communication of himself to us in a way which cannot be conceived as separable from God's personal love and our response to that love.

[3]Rahner, p. 133.

[4]Ibid., p. 134.

Rahner cites in support of his theory of human existence as being openness to the infinite, the human experience of "infinite longing, radical options, discontent which cannot find rest, anguish at the insufficiency of material things, protest against death, the experience of being the object of love whose absoluteness and whose silence our mortality cannot bear, the experience of fundamental guilt, with hope nevertheless, remaining."[5]

Rahner's transcendental anthropology implies that the meaning of human existence is not exhausted by the merely psychological, sociological, or biological, but reaches beyond the corporeal towards God as the fulfillment of all existence. Richard McBrien summarizes Rahner's anthropology as follows: ". . . the human person is capable of transcending himself or herself in the knowledge of God to whom his or her own life is oriented because God is already present in the person as the transcendental force or condition which make such knowledge possible."[6]

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[5]Ibid., p. 138.

[6]Richard McBrien, Catholicism (Minneapolis: Winston Press, 1980), I, 130.

Rahner's Theology of Freedom

The human person, because of her or his transcendence is open and undetermined, is responsible and free. Freedom at this existential level is not the same as what the empirical sciences speak of as freedom. When they deal with freedom, they are considering the relation of one phenomenon to another in time and space, and at this level of inquiry they fail to find freedom. Freedom and responsibility are not in themselves a datum of empirical investigation. Even when in everyday affairs we speak of being free in regard to this and unfree in regard to that, we are not referring to a specific phenomenon which can be indicated unambiguously. We are referring to the application and concretizing of transcendental experience, but in a way that is quite different from the experience which is the object of scientific scrutiny.

Responsibility and freedom, as Rahner considers them, refer to subjective experience, i.e., that which is known directly when a person experiences himself or herself but not when he or she is the object of scientific reflection.

> When the subject experiences himself (sic) as subject and hence as the existent which through its transcendence has an original and indissoluble unity and self-presence before being, and when this subject experiences his action as subjective action although it cannot be made reflective in the same way, then

> responsibility and freedom in an original sense are experienced in the depth of one's own existence."7

What Rahner calls transcendental freedom is a person's ultimate responsibility to be herself or himself. This freedom appears, not only in self-consciousness but also in self-actualization; that is, it is always mediated by concrete reality. However, this mediated freedom, unlike freedom in its transcendent origin, is always ambivalent. Freedom in its origin and incarnated freedom can be distinguished separately; yet, they form a single unit of freedom.[8] Whether or not, in a specific instance an action on the part of an individual can be interpreted as the product and incarnation of original freedom is a question which cannot be theologically determined while that person's history is still in progress. The incarnation of transcendental freedom completely eludes unambiguous reflection.[9]

Salvation in Rahner's scheme is not "a future situation which befalls a person unexpectedly like something from outside . . . nor does it mean something bestowed on him (sic) only on the basis of a moral judgment." It means, rather, the final validation of a person's true self-

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[7]Karl Rahner, Foundations of Christian Faith (New York: Seabury Press, 1976), pp. 37-38.

[8]Ibid., pp. 36-37.

[9]Ibid., p. 37.

understanding and actual self-realization in freedom before God. It is the definitive acknowledgement that the person has accepted her or his own self as it is "disclosed and offered" to her/him in the free choice of transcendence.[10]

Freedom in Contingency

The human person, in spite of being free subjectivity, experiences herself or himself as being at the disposal of things over which she/he has no control. First, as transcendental subjectivity, the person is in the presence of being as mystery--a mystery which simultaneously is a relationship which is not subject to its own power. It is experienced as something which was established by another and is grounded in ineffable mystery.[11] Moreover, human freedom is situated in a world of persons and things with a history, which situation is not chosen but given in advance. It is part of the nature of humans to be historically conditioned and yet to both know and be capable of taking a stance towards their history. "Being situated between the finite and the infinite is what constitutes man (sic)."[12] The human person never establishes her/his freedom in an

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[10]Ibid., p. 39.

[11]Ibid., p. 42.

[12]Ibid.

absolute sense, never fully realizes her/his potential in the world. Paradoxically, the human person is at once doer and maker but also receiver and being made. Always, the person is a synthesis of possibilities presented to her/his freedom--a synthesis of what is self and what is other, of action and suffering, of knowing and doing. In a sense the human person is the unknown because reflection can never grasp the totality of the ground from which she/he emerges and towards which she/he tends in self-actualization.[13] Freedom, then, does not consist essentially in being able to do this or that, it is fundamentally the subject's being responsible for her/himself. "Ultimately he (sic) does not do something, but does himself."[14]

Guilt

Rahner bases his theology of guilt on the concept of freedom that is actualized in an absolute "Yes" or "No" to the source and end of transcendence which is called God. This freedom is not asserted immediately or exclusively to the God of "transcendent presence" but to the God of categorical reflection, to a God in concepts, even perhaps to a false god. That an act be an act of freedom there must

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[13] Ibid., p. 43.

[14] Ibid., p. 94.

be present in the "Yes" or "No" on the categorical level a corresponding "Yes" or "No" to the God of original, transcendental experience. Freedom is the ability to say "Yes" or "No" to God and that "Yes" or "No" is a radical affirmation or denial of one's transcendent self. Herein, it seems, lies the possibility of radical guilt. Human freedom involves the possibility of denying oneself in such a way as to say "No" to God and not merely to some norm of conduct which is rightly or wrongly called God's law, or to some inadequate notion of God.[15]

Possibility of Sin as a Permanent Existential

Sin, in Rahner's schema, is the act of saying a radical "No" to the source and goal of one's transcendence, i.e. God. We know that we can sin; however, we never know with ultimate certainty whether or not we actually are sinners. All of our decisions are co-determined by previous decisions, both our own and those of others. Therefore, though we encounter ourselves as having exercised freedom, the actual situation of our freedom is not completely accessible to subsequent reflection. Nevertheless, the

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[15]Ibid., pp. 97-101.

possibility of sin belongs to the whole of a person's life and can never be eradicated.[16]

Original Sin

The person as free subject is a being in the world of other persons and in history. That is, she actualizes herself in a situation that has been determined by history and by other persons. The guilt of others is a co-determining factor in the situation in which she actualized herself in freedom.[17] Her experience indicates that there are objectifications of personal guilt in the world which, because they are part of the situation in which she makes her decision, exercise an effect which makes her free decisions difficult and painful. Even the good which she intends by her free act may be contaminated by the consequences of the guilty acts of others. Christianity asserts that this co-determination of the situation of each person by the guilt of others is universal, permanent and original.[18] ". . . . the situation of our own freedom bears the stamp of the guilt of others in a way that cannot be eradicated."[19] If this determination

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[16]Ibid., p. 104.

[17]Ibid., p. 107.

[18]Ibid., p. 109.

[19]Ibid., p. 111.

of our situation by guilt were only a particular event then we would be at a loss to explain our experience of it as universal and ineradicable. Original sin means specifically that the determination of our situation by guilt is an element within the history of the freedom of the human race and that this element became present at the very beginning.[20]

In summary, then, Rahner sees the human person as, though finite, also oriented towards the eternal, and within the limitations imposed by the decisions of others and by history, capable of living in affirmation of that eternal dimension. Indeed, though the eternal is not co-extensive with the human, it is so much a fundamental aspect of humanness as we now know it, that to say "No" to the eternal or to God is synonymous to saying "No" to oneself.

Edward Schillebeeckx's Theological Phenomenology

Like Rahner, Schillebeeckx sees the human person as oriented towards the transcendent. Schillebeeckx contends that any real "proof" of God's existence must be grounded in human experience, i.e., to be convincing it must be an explication of what is implicit in human experience. Here, Schillebeeckx differs from the agnostic humanist for whom truth resides only in prereflective experience--explication

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[20]Ibid., p. 112.

of that experience is considered subjective projection.[21] For the Catholic, says Schillebeeckx, the starting point of belief is not revelation but human experience ". . . as a human being I cannot accept revelation unless I have previously come to the conclusion on the basis of human experience that there is a God."[22] Belief in revelation presupposes an existence which is seeking to give a sense and significance to life amid the chaos in which we live.

In his discussion of human existence, Schillebeeckx uses the term mystery to indicate the condition of being involved in the transcendent in such a way that we can never stand outside it and grasp it objectively. Mystery is not a "temporary ignorance concerning things we cannot explain, but involves recognizing that the reality in which we live is not an invention of man's (sic) mind, and therefore transcends us."[23] The natural recognition of God and the experience of one's finite existence in a finite world are fundamentally united human experiences. The affirmation of this reality transforms our humanity into a mystery of hope and promise; that is, we are, already, within our humanistic experience, involved in a hope and a promise which is

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[21]Edward Schillebeeckx, God and Man (New York: Sheed and Ward, 1969), p. 61.

[22]Ibid., p. 63.

[23]Ibid., p. 68.

further affirmed by revelation.[24] Surrender to the mystery which permeates our existence is the appropriate human response to that mystery. "Supernatural faith, and supernatural hope, and supernatural love thus find in human experience a preliminary onset of natural faith, a natural hope and a natural love in answer to God's creative testimony in himself."[25]

Schillebeeckx's anthropology has a fundamental interpersonal dimension. The human person is not a closed awareness that subsequently incarnates itself in this world through bodiliness. The person is an "I-in-the-world.[26] The human body is not just something I have, but also who I am; i.e., it belongs to the human person's subjectivity. Since I can only live my life in the body, I become myself only in going beyond myself. I know myself only in presence to the world of other persons and things. To be human, then, means to be fundamentally oriented towards others.[27] The law of human being is that "every conscious experience and personal activity of him (sic) has an unbreakable

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[24]Ibid., p. 69.

[25]Ibid., p. 76.

[26]Ibid., p. 189.

[27]Ibid., p. 187.

connection with the life of human beings lived in common in the world."[28]

This law of a person's being involves all personal activities even when such activities constitute an entrance into the life of grace, i.e., life in union with God.[29] This interaction with other human beings involves mutual self-revelation and believing trust in the face of the essential incompleteness and insufficiency of all bodily revelation. Thus, viewed from the purely anthropological perspective, our experience of human existence as interpersonal, constitutes a prefiguration of God's revelation of himself to us. God's self-revelation is addressed to an I-in-the-world; hence it cannot reach our inner selves in a purely vertical manner. The vertical movement, in order to be perceived, has to be accompanied by a corresponding horizontal movement addressed from our human world, God becomes known to human persons in the world of human relations and things and human history.

Our world is not only one which has a human history, but also one which has a salvation history, and this human and this salvation history are not two separate movements but are inextricably united.[30] Schillebeeckx spells out in

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[28]Ibid., p. 188.

[29]Ibid.

[30]Ibid., pp. 190-191.

greater detail the ways in which he sees this unity of human and salvation history in Christ the Experience of Jesus as Lord. Here he reiterates that nature is not a fixed and a given, but is itself involved in history, and the theme of history is integrity in a truly human and free way.[31] Living out that integrity involves (a) awareness that our surroundings conceal as well as reveal the good and the true; therefore we need a standard by which to judge critically; (b) awareness that the critical force of reason is dependent on the historical circumstances of human reason; (c) awareness that the past and the present are involved in human history and are therefore ambiguous, i.e., they reveal and conceal the true and the good. It follows that we need to be both self-critical and critical of phenomena.[32]

Though we do not have a pre-existing definition of human nature, we do have a set of anthropological constants. These are conditions which must always be present in any human action and which constitute norms or values.

Relation to Corporality, Nature and Environment. Relationship to one's own body, to nature and to environment is constitutive of our humanity; therefore salvation is also

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[31]Schillebeeckx, Christ the Experience of Jesus as Lord (New York: Seabury Press, 1980), p. 132.

[32]Ibid., p. 733.

concerned with issues arising from this relationship. Our relationship with nature and our own corporality come up against boundaries which have to be respected. What is technically possible is not necessarily ethically desirable.[33] We need to create an appropriate human environment; therefore the rational alteration of nature is necessary. (A metacosmos is better than a natural cosmos.) Technology is a service towards a livable humanity. However, the human being is not only reason, but also temperament; not only freedom, but also instinct. We are not meant to merely control the world but also to contemplate it, to play and to love. Christian salvation involves ecology and the conditions and burdens which a particular life lays on human beings.[34]

Relationship with Other People. Human personal identity involves relationship with others. I need authorization by society to be in my own name and in my own identity a personal and responsible self.[35] Being a self involves an individuality which is limited. I need to be allowed to be my inalienable self within my essential limitations. I owe similar confirmation to the other. A

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[33]Ibid., p. 734.

[34]Ibid., p. 736.

[35]Ibid.

co-humanity in which we encounter the other as end and not just as means is an anthropological constant which must apply to all and not just to a privileged few.[36]

Relationship to Social and Institutional Structures. In the course of human history social structures and institutions become independent and develop an objective form. When they become independent they give the impression of being unchangeable. However, though they may have deep and immutable structural constants, they are contingent and changeable. Structures and institutions should aim at making possible human freedom and the realization of values.[37]

Conditioning of People and Culture by Time and Space. Human beings are inextricably involved in time and space. The dialectical tension between nature and history means that there will be forms of suffering on which we have no influence through technology or social intervention.[38] The inescapability of historicity and finality gives rise to the question of meaning. Human history is a hermeneutical undertaking--a task of understanding one's own situation. Truth is "remembered" truth which has to be realized in the

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[36] Ibid., p. 737.

[37] Ibid.

[38] Ibid.

here and now. ". . . . Adopting a standpoint outside historical action and thought is a danger to true humanity." We need a critical remembrance of the great traditions of humankind, especially the religious traditions. This critical remembrance will be a "necessary stimulus" in search of the norms for action which here and now further healthy and realizable humanity.[39]

Mutual Relationship of Theory and Practice. Through the relationship of theory and practice human culture as understanding of meaning, changing of meaning and improving the world can be given permanence. On the subhuman level the principle of instinctual adaptation operates. Without the dialogue between theory and practice the power of the strongest and the fittest would dictate what is good and true even on the human level. A culture which is increasingly humanizing and therefore a bearer of salvation is one which emerges from on-going dialogue between theory and practice.[40]

Utopian Element. Utopian systems express what ultimately inspires people, what humanity chooses in the last resort. They are concerned with the future, the way in

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[39]Ibid.

[40]Ibid., p. 740.

which a human society gives specific sense-making form to the fact of contingency, finitude, suffering, failure, and death. They constitute alternatives to an inadequate existing "attribution of meaning" and are a protest against it. Schillebeeckx describes utopias as "cognitive models of reality" which allow nature and history to be experienced as a meaningful whole. In most of them man (sic) is experienced as an active subject who furthers humanity by shaping the future. They are characterized by a form of faith in a future which cannot be scientifically demonstrated. "In this sense 'faith' the ground of hope is an anthropological constant . . . without which human life and action worthy of men (sic) and capable of realization becomes impossible, man (sic) loses his identity and either ends up in a neurotic state or irrationally takes refuge in horoscopes and all kinds of mirabelia".[41]

Synthesis of Six Dimensions. The reality which heals and brings salvation lies in the synthesis of these six dimensions. They influence one another and inter-penetrate. That synthesis is also an anthropological constant; failure to recognize one or other dimension uproots the whole.[42]

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[41] Ibid., pp. 740-741.

[42] Ibid., p. 741.

> Thus Christian Salvation, in the centuries-old biblical tradition called redemption, and meant as salvation from God for men (sic) is concerned with the whole system of co-ordinates in which man can be really man. (sic) The salvation--the wholeness of man--cannot just be sought in one or other of these constants, say exclusively in "ecological appeals" in an exclusive "be nice to one another" in the exclusive overthrow of an economic system (whether Marxist or capitalist), or in exclusively mystical experiences: "Alleluia, he is risen!" On the other hand, the synthesis of all this is clearly an "already now" and a "not yet". The way in which human failure and human shortcomings are coped with must be termed a form of liberation (and perhaps its most important form). In that case that might then be the all-embracing "anthropological constant" in which Jesus, the Christ wanted to go before us.43

Summary of Foundational Theological Anthropology

The anthropological formulations of both Karl Rahner and Edward Schillebeeckx yield some notions of foundational significance for this dissertation both in respect to pastoral care and counseling itself and to the problem of dependency on prescribed drugs in women which is its specific focus. The validity of pastoral counseling as a ministry and as a discipline depends on the possibility of relating the message of salvation to the existential problems which beset humanity. From what we know of alcoholism and other drug dependencies, there are specific spiritual issues involved in the problem of drug abuse--issues of guilt,

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[43]Ibid., p. 743.

transcendence, suffering, and hope, all of which relate ultimately to the meaning of human existence. This relationship will be discussed in greater detail in subsequent chapters. However, at this point it is necessary to designate in a general way what may be helpful in contemporary Catholic theology as well as what is still lacking in the Catholic ethos from the perspective of pastoral care and counseling of women who suffer from drug dependency. The following are significant highlights from Karl Rahner's transcendental anthropology.

I. The human person is openness to the transcendent--is in communion with the eternal prior to any awareness of revelation or objectivated dogmatic statements.

II. All people enjoy graced existence, i.e., participation in God-life. By this participation each is given the power and the possibility to choose life in its fulness.

III. The realm of human experience has an immediacy and a validity which cannot be totally captured and objectified through reflection.

IV. The human person is free at the level of fundamental existence, i.e., is capable of giving assent to, and of choosing life.

V. Existential human freedom is not subject to scientific objectification.

VI. Freedom is ultimately responsibility to one's transcendent self.

VII. Immediate experience is a mode of knowing which is not strictly empirical.

VIII. Human freedom is never fully realized in history--it is an on-going movement.

IX. The consequences of one's previous choices as well as those of others make the exercise of freedom difficult and even painful.

X. A condition rooted in the beginnings of the race in the area of freedom makes the exercise of freedom fundamentally difficult, but the possibility of exercising freedom is not thereby negated.

Some basic tenets of Schillebeeckx's phenomenological anthropology are as follows:

I. Human persons participate in divinity through God's self-communication with us.

II. The self-communication of the divine is perceived in relation to the world of persons, things, and history.

III. The human being is not a fixed, describable entity. However there are necessary attendent conditions for humanness.

A. Relationship to other persons

B. Relationship to body and environment

C. Relationship between theory and practice

D. Relationship to structures and institutions

E. Relationship to time and space

F. Ability to dream of and strive towards an idealized future

G. On-going unification of the foregoing six conditions.

IV. All of these anthropological constants are the loci of salvation.

While there are several elements in the theological anthropologies of both Rahner and Schillebeeckx which indicate optimistic possibilities for human beings, the immediate question which arises is, is this sampling of contemporary Catholic theology good news for women? For the woman reared in the Catholic form of Christianity, traditional Catholic theology in both its theory and its practice can hardly be described as tidings of great joy. Like all other patriarchal religions it has been experienced as alienating, repressive and subjugating. Yet, Catholicism has traditionally upheld the natural foundation of religion, a focus which should have augured well for the preservation of the healthy natural elements in primitive matriarchal religions and social systems. Here again, we have two contemporary Catholic theologians rethinking and reformulating the natural theological basis of Catholic theological anthropology. Does their approach give reason to hope that Catholicism will become thereby a more healthy environment for women? First I will consider what might be termed hopeful in the theological anthropology of Rahner and Schillebeeckx.

Then I will indicate what is from a feminist point of view still lacking.

Principally, both theologians affirm the subjective experiential basis of the divine and the eternal in human beings, and the innate human impetus towards the unfolding of what is divine in each person. Both acknowledge the cultural relativity and bias in religious formulations both revelational and doctrinal, while asserting an authentic transcendent core within them. Both agree on the impossibility of capturing the human personality, or human experience in merely empirical terms. In other words they affirm the mystery and sacredness of the human person. Each affirms the essential unity of matter and spirit. In particular, Schillebeeckx does so in terms of the sacramentality of material reality, that is, the capacity of material reality to be the bearer or the transmitter of divine vitality. For both, the eternal resides both within and beyond human persons. Thus, all participate in divinity; yet, no one can claim exclusive divine prerogatives. Both realistically acknowledge the tension and suffering which inheres in the human experience of being finite because of corporality and yet charged with an insatiable desire for the infinite. Both perceive the fundamental difficulty humans have in actualizing their freedom to become what they fundamentally are, transcendent (capable of breaking through the bonds of finitude) and ascribe that difficulty to a primeval human

choice against life which has affected the entire cosmos. However, both assert the enduring possibility of ultimately attaining the infinite in spite of that primitive negative choice and ongoing negative choices on the part of individuals.

However, whereas Rahner remains abstract in his metaphysical formulations, Schillebeeckx in his anthropological constants spells out more concretely the actual incarnational dimensions of his theology. These constants suggest the actualities in which the transcendent unfolding of the individual and the race are either facilitated or impeded.

So far, it would seem that Catholicism has at its disposal a fundamentally salugenic vision of the human person, containing a hope-filled affirmation of on-going possibilities for limitless growth in freedom, with realistic acknowledgement of the difficulties and struggles which must attend the exercise of that freedom. Why, then, cannot I, a woman, feel inspired and enthusiastic about the future of pastoral care and counseling in the Church which can use these theologies or about the future of women in the Catholic Church? For several reasons. First, in the writings of these two leading Catholic theologians I fail to find any mention of the experience of women either past or present as a necessary component in hermeneutics. If religious formulations must correlate with religious experience, how can we hope for anything but grossly truncated and one-sided theologies,

when, to date, the theology of the Catholic Church has been composed largely without reference to millenia of accumulated female experience of the transcendent and of the patriarchal suppression of the same. Not only that, but the entire Judai-Christian record of suppression of goddess religions and the perpetuation and enhancement of patriarchal religions indicate that Christian and Catholic religious formulations have been geared towards the obliteration of woman's wisdom regarding those very elements which Schillebeeckx designates anthropological constants: the body, the cosmos, history, social institutions, and other people. Moreover, they have been devoid of any influence from women's dreams and visions regarding alternatives to male life-destroying ideologies and visions of the future. Without the creative integration of woman's wisdom into provisions for the realization of the human person (with the characteristics which Rahner and Schillebeeckx delineate) the theological anthropology of contemporary Catholicism will have no more effect on the conduct of daily life than the Vatican Museum art treasures have on the production of the multitudes of plastic Jesuses which adorn the shelves of "religious art" stores.

Feminist Critique of Theological Anthropology

Schillebeeckx says that I need authorization by society to be in my own name and in my own identity a

personal and responsible self. In Schillebeeckx's understanding of the human person as an I-in-the-world-with-others, authorization is not the same as permission, as though others have the right to bestow or withhold personhood. No, what is meant, is that to be author, or myself, I must do so in relationship with others. It is possible for society to be so oppressive as to make personhood impossible to attain. If we consider the various forms of oppression which exist, we might say that only a minority of the human race receive authorization from society to become personal and responsible selves. To women as a group this authorization is denied. Women's identity is already determined within the stereotypical roles which society has set for her. It is, to quote the title of Elizabeth Janeway's book on the social role of women, "man's world, women's place."[44] This is the fundamental level of oppression--it is oppression of woman's spirit. Beverly Harrison describes this level of oppression as it finds shape in the ways of describing a woman's departure from social norms:

> The moral onus of sexism can be seen if you pause to consider what is entailed when an individual male is told that he is a defective male and what an individual is told when she is charged with being a defective female. Both individuals can be deeply wounded at the psychological level, by such an accusation. There is no difference in that regard, but the male so charged is told that he is not a man. The woman is told that she is not feminine. That is a very different thing. In the accusation

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[44] Elizabeth Janeway, Man's World, Woman's Place (New York: Delta Books, 1971).

> directed to the male there is a dominant note which suggests omission. There is always some suggestion implied that the male in question has failed to go forth and meet the world as he ought to have done. The omission is usually one of act or initiative and the charge suggests some failure in the arena of activity. The female, on the other hand hears the charge of defective femininity differently. The charge will most often arise because she has been guilty of commission. She will have said something she should not have said, aspired to do or have done something she should not have done. In short, she has crossed that invisible but powerful boundary out of her territory. The charge of being "not feminine" I submit, is aimed at thwarting initiative. Its message is "Go back."[45]

In whatever way a woman is stereotyped, whether it be as spotless virgin, loving mother, play girl, or whore, she is confined to a place which strictly defines what she can and cannot do; and who she can and cannot be.

Nurturing, Diffusion, and Loss of Self

It is debatable whether female infants show innate tendencies towards relatedness more markedly than do male babies; however, what is not debatable is the fact that from infancy, females have been encultured to nurture others. To be other than nurturing is to be unfeminine, indeed even unnatural. Tending the young and the need to be attentive to sights and sounds around in order to protect their

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[45]Beverly Wildung Harrison, "Sexism and the Contemporary Church: When Evasion Becomes Complicity," in Alice L. Hageman, Sexist Religion and Women in the Church (New York: Associated Press, 1974), p. 197.

off-spring has engendered in women qualities which the culture has encouraged and even mythologized. To bear and rear children, the woman must enter the world of the other, must give of herself in unconditional love. The constant demands of mothering, which do not cease even during the night, draw her outwards in a way which eventually make it wellnigh impossible for her to return to herself--to be quiet and centered. This phenomenon is apparent in a group of women--how difficult it is to bring a woman's assembly to order. In its extreme form this excessive other-centeredness is the ground of the stereotyped image of women as gossipy and meddling. In short, like Martha, woman is often troubled and busy about many things and has difficulty finding her own center and focus. Succumbing to this culture-induced busyness robs women of the opportunity and eventually the ability to tend towards the transcendent out of her own center. In the church this busyness takes the form of good works: cleaning the sanctuary, running bake sales, attending religious services. But when a woman reaches middle age, she feels an inner vacuum and realizes that for all the good works she has done, and the prayers she has said, her spiritual life has shriveled.

Derived Identity and Woman's Personhood

Consider the case of a woman married to a gifted male who squanders his talents, becomes involved in criminal activities, and ends in prison. It is commonplace to hear people say of him, "what a waste of potential." It is not so common to hear similar comments regarding his wife. She is assumed to have fulfilled her potential in bearing and rearing their children, in supporting and encouraging him in the days of his success, standing by him through his trial, and, of course, being faithful to him during his imprisonment. This is a scenario of derived identity in its more pathetic form.

Throughout her entire life woman takes her identity from someone else, usually a male. She is her father's daughter, her children's mother, her husband's wife. The assumption of her spouse's name at marriage symbolizes the relinquishing of whatever identity she may have attained or the transference of her identity from that of ward of her father to ward and/or helpmate of her husband. Living in the reflected glory of another, the woman enjoys the dubious privilege of not having to risk establishing herself as someone in her own right, but she is also rendered fundamentally dependent on others for her very identity. This radical dependence makes her very vulnerable to failures of or rejection by significant persons in her life. In her

powerlessness to determine her own life she becomes a nagger or she manipulates others in her effort to get her own needs met. To be open and tending towards the transcendent requires a personal identity and a measure of power to shape one's world, a power which few women possess, and then only to a minimal extent.

Woman's Body and Personhood

Daniel Maguire lists among the attributes which enhance the moral sensitivity of women her attuneness with bodily existence. I say, "Yes, woman is attuned to bodily existence, but to whose, her own or other peoples?" Culturally woman has been reared to ambivalence about her body and to a high degree of alienation from it. Woman's body has been treated as an instrument--for male pleasure and for bearing children. She has been told how her body should look, weigh, feel. She is the victim of male-created standards of pulchritude. Mary Daly with her customary lethal insight summarizes the condition of women in a culture which objectivates and exploits her body:

> Gynecological/therapeutic/cosmetic preoccupation conceals the patient's emptiness from her Self. It drives the splintered self further into the state of fixation upon the parts that have become symbols of her lost and prepossessed Self. Reduced to the state of an empty vessel/vassal, the victim focuses desperately upon physical symptoms, therapeutically misinterpreted memories and "appearances," frantically consuming medication, counsel, cosmetics, and clothing

> to cloak and fill her expanding emptiness. As she is transformed into an insatiable consumer, her transcendence is consumed and she consumes herself.46

Women and the Idealized Future

Living through a derived identity means that women's energies are invested (I might say squandered) in actualizing the male dream. It is hardly necessary to point to the proliferation of nuclear arms and the amount of human resources that go into this proliferation to indicate that the male dream is an illusion of the triumph of power and greed. Women have no part in that dream other than what loyalty to sons, lovers, and husbands imposes on them. The world is shaped according to men's ambitions not women's dreams. Yet, to live and unfold in the light of her transcendence woman needs to have her place in the creation of the future out of the stuff of her own visions, perceptions, and values.

Women's Transcendence and Institutions

Women's powerlessness to translate her dreams into future realities is perpetration by excluding her from the decision making levels of institutions both civil and

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[46]Mary Daly, Gyn/Ecology (Boston: Beacon Press, 1978), p. 233.

ecclesiastical. The few women who do reach any level in which decisions are made are mainly those who have so internalized the male ethos that they are no longer a threat to it. In the Catholic Church decisions are made and handed down from above--above being the abode of the all-male hierarchy. The exclusion of women from levels of influence and power both degrades woman, impoverishes the culture, and deprives both women and men of the creative power of that transcending spirit which resides in all.

Deficiency of Abstract Theological Anthropology

These brief reflections of the condition of women vis-a-vis secular and ecclesiastical culture brings me to the fundamental deficiency in the theological anthropology of Rahner and Schillebeeckx. Schillebeeckx refers to it himself when he lists as an anthropological constant the relationship between theory and practice. However, that relationship is not righted by simply putting into practice what he and other metaphysical theologican propose however accurate and lucid their formulations. Rather, salvation lies in the resourcing of the theological in the experiential so that the struggle to live out that openness towards the transcendent of which these theologians speak is in process simultaneously with the reflection upon and articulation of the wisdom which is thereby brought to birth. In terms of

the subject of this dissertation that bonding of the theoretical and the practical means the engagement of the church, both immediately and reflectively, in the liberation of women.

Salvation History and Women's Personhood

Schillebeeckx says that God becomes known in human history so that history becomes salvation history. He also says that the relationship to time and space is an anthropological constant through which a person's transcendent self-hood is articulated. But history has been literally his story; the part women have had in the shaping of the world has long since been suppressed. The suppression of woman's share in history has two significant consequences; the story through which salvation becomes concrete for us is distorted and, moreover, it is a story in which woman does not find herself and with which she cannot identify. Take for instance, the story of Abraham which recounts in partiarchal terms the beginnings of salvation history. Here, held up for our admiration and emulation as a prototype of faithful dedication to the call the transcendent is a man who will kill his own son in testimony to a perceived ideal. This doesn't sound too unlike the colonel who standing in the carnage of Ben Tre during the war in Viet Nam could say that it was necessary to destroy the village to save it. It is impossible for a woman to identify with that kind of

"obedient faith." What if the story of the beginnings of salvation were herstory, Sarah's not Abraham's. Wouldn't we have a quite different view of how we are to be involved in the on-going movement of salvation. The Almighty Father God, more a reflection of men's fear of powerlessness and vulnerability than an image of the Living God is indeed the God of Abraham, Isaac and Jacob. Where, women ask, is the God of Sarah, Rachael and Ruth--our God?

Theological Implications of Story

The story method which will be used in this dissertation is not merely a way of gathering data--as a mode of data gathering it has some weaknesses, the most obvious being the subjective nature of the account. However, it is a method in keeping with the basic assumption of transcendent anthropology, i.e., whatever appears in objectivated form is first experienced. I believe that the experience of women has been too often ignored or discounted by the theological and human sciences. It is therefore in keeping with my own beliefs and with the anthropological assumption of this dissertation that I begin my research into the problem of dependency on prescribed drugs by consulting the experiences of women who suffer from this malady.

Secondly, it is believed that the very formulating and recounting of one's story, is, in itself, healing. In A

Search for God in Time and Memory John Dunne relates the recounting of one's story to the notion of repetition as conceived by Freud and Kierkegaard. In the case of Freud the purpose of repetition was said to be the assimilation of one's past experiences.

> Thus in infancy the events that occur, one's relationship to father and mother, brothers and sisters are repeated, according to Freud's way of thinking through the course of one's life. The aim of the repetition would be the full and complete assimilation of these primordial experiences . . ."[47]

Kierkegaard, Dunne says, uses the term appropriation to describe the purpose of repetition. Thus, according to Dunne, repetition is more than the mere turning of the wheel; it is "a forward movement of the vehicle because the wheel is turning." Repetition itself is the turning of the wheel and assimilation is its forward movement. This movement can take place on three levels: the immediate (concerns are focused on the present situation), the existential (concerns extend to the past and future) and the historical (when the past and the future is not just that of the individual but that of humankind).

John Narvone, in a book which he co-authored with Thomas Cooper, Tellers of the Word says that every human story has three dimensions: past (called to mind by memory)

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[47]John S. Donne, The Search For God In Time and Memory (London: Macmillan, 1967), pp. 59-60.

present (contacted by awareness) and future (brought alive by anticipation). Life stories take their meaning from the end; the teller selects and emphasizes data from the past in terms of the anticipated end. Human life stories are the product of the understanding which the story teller has of her or his own life.[48] Thus the story has eschatological import; it indicates a hope for the future in the light of which the past and the present are seen as meaningful.

In the very telling of her story, then, woman can begin or continue a transcendent movement. She claims the experience as hers in the recounting of it. In the process of recounting, in that assimilation and forward movement of the wheel, she can move beyond where she was before she worded her experience. The experience which she really claims as hers takes on by that fact a life, a power and possibility. That, I believe, is one of the secrets of the success of twelve step programs. The initial step, the owning of one's addiction opens up to a further realization and movement, the acknowledgement and acceptance of powerlessness over the addiction and so on. Of course the possibility of terminating one's story is always there. I can own my powerlessness and despair or I can own it and place my trust in a power greater than myself. But once I

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[48]John Narvone and Thomas Cooper, Tellers of the Word (New York: Le Jacq, 1981), pp. 42-43.

begin to claim my story I am forced to choose--to be responsible for myself. In that autonomy is the possible beginning of selfhood. Moreover, when the listener hears woman's story, really takes it in, not as data, but as the unique recounting of a personal experience, the listener (in this case the church) can no longer discount it but must choose to be changed by what is heard or to become more hardened of heart. To tell and to hear a story is to involve oneself in possibility for change.

In Chapter 2 we will hear and examine the stories of seven women whose journey towards selfhood lead them to a land which promised a better life but which betrayed that promise and trapped them in an island of despair.

Chapter 2

EXPERIENCE OF DRUG-DEPENDENT WOMEN

"At first I was bitter toward the medical profession. Fourteen years of being advised to take pills rather than wait for the pain to hit. I had never been without my drugs. I took pills for pain, I took pills to sleep. I took mild tranquilizers."[1] That was Betty Ford speaking--the woman married to the thirty-eighth president of the United States. There was a time when the word alcoholic conjured up an image of the skid-row bum with unlaced shoes sleeping in an alley with an empty wine bottle beside him. That was the time when we thought a drug addict was a hollow-eyed youth with needle marks on his arms just arrested for holding up a bank teller. Now we know better, or we should. The alcoholic may be the prosperous lawyer driving to an office past the alleys where the bums are sleeping. The drug addict may be the neat, efficient bank teller cashing a check for a greasy haired youth. Chemical dependency is one of the most democratic diseases; it strikes the young, the old, the conservative, the liberal, priest, doctor, single, married, homosexual, heterosexual, atheist, or believer.

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[1]Betty Ford, The Times of My Life (New York: Ballantine Books, 1978), p. 305.

Ordinary Women

The women whose stories follow could be anyone's mother, sister, or friend. You might meet them in the market, or the bowling alley, in church or at a PTA meeting. They are seven of the estimated million and a half women who are drug-dependent.[2] However, these women are more lucky than many others because they are recovering.

The seven women whose stories are told here range in age from forty-five to fifty-two. Five are married, two divorced. All of them have grown children. All of them have completed a hospital chemical dependency program within the past three years. They are not for that reason normative of drug-dependent women. But they are typical in this: they are ordinary people who some years ago never dreamed that they would become dependent on drugs. Their stories are recounted here because they can tell us something about how anyone can become dependent on drugs, something about the progress of the disease, the cultural and religious milieu which engenders it, and, what is most important, they indicate that there is hope for the afflicted.

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[2]In order to protect the privacy of these women and families all personal and place names have been changed.

Stories as Models of the Selfless Woman

The word selfless in this heading is used with double entendre because these drug-dependent women were selfless in two ways. First, they took care of others, deferred to other's needs and demands, while neglecting their own feelings and needs. Secondly, they failed as a result to develop autonomous selves. This failure to reach an adequate degree of self-differentiation was both a cause and a result of their dependency. It was a condition which preceded the use of prescribed drugs and it was aggravated by their use. Cultural factors are not geared to the development of autonomy in women. In particular the period in which these women were adolescents was not a hospitable milieu for nurturing selfhood in women. They were expected to marry young before their identity was established (the average marriage age for the seven was eighteen) and to derive an identity from their relationship to their husband. Without an autonomous self to give, they were fundamentally frustrated by all the demands to give of themselves to husband and children. They are living examples of the frustration of being, on the one hand, expected to give to others while, on the other hand, being denied the opportunity to become what a woman is expected to be: a self-transcending self.

Purpose of Stories

The stories of these seven drug-dependent women are presented here because we need to hear from them what it is like to be dependent on prescribed drugs. They will tell us about the way their dependency began, developed and how it was finally arrested. Looking back they tell their stories from the point of view of people who have passed through the ordeal and can now make sense of it. Their stories take on a certain cohesive meaning. What they have chosen to tell out of the many details of their lives is chosen in light of the way they now understand and interpret their experience.

In order to formulate a tentative profile of the drug-dependent woman I will gather from these stories the salient features which the tellers appear to have highlighted. I will then synthesize the features the stories have in common into a cohesive picture. Unique elements of individual stories will be examined for their meaning and for the light they may throw on the problem. Augmented by further information from the literature of drug dependency discussed in Chapter 3, this profile will form the basis for a fictional case study which will be used in the model of pastoral care for the drug-dependent woman presented in Chapter 5.

Bea's Story

"They (a bottle containing 100 Valium) were sitting down on the counter. I poured myself a glass of milk--I was getting ready to go to work . . . I saw the bottle sitting there and I just picked it up . . . poured that whole 100 into the glass of milk and just drank it down. I went into the bedroom and took the phone off the hook, lay down on the bed and went to sleep. I went to sleep. As for committing suicide . . . at that moment . . . consciously I wasn't aware of what I was doing." This is how Bea, a fifty-two year old woman describes the end of her seven-year relationship with Valium. That journey began in 1973 when her doctor prescribed Valium for an apparent acute stress reaction. However, Bea's life journey prior to 1973 may have some relevance to the event which happened May 14, 1980.

Bea was an only child who lost her mother to tuberculosis when she was four. She remembers nothing about her mother except what she was subsequently told, that she had been ill for a long time and that one day when Bea returned home from kindergarten, her mother took her in her arms and just lay back and died. A few years later her father married a woman ten years older than Bea. From the beginning stepmother and child conflicted. There were beatings until, at the age of eight, Bea was made a ward of the court. After that "she never laid a hand on me" but there was plenty of

verbal abuse, Bea remembered. Of her upbringing, Bea says, "I raised myself." Her early life was a saga of moves, living with relatives for a few months, then back home until another upheaval sent her packing again. At the age of twelve she was sent to a convent boarding school where she was happy. There were rules but the Sisters were lenient with her. Learning was difficult because of her disrupted background--to this day Bea feels inadequately educated particularly when it comes to writing. When she was almost sixteen, Bea's time at the convent home ended and she came back to live with her parents and to attend a local public school. The transition was difficult. Used to an all-girl school, she was terrified of boys and ditched school to avoid them. Bea describes her sixteenth year as one of constant fighting with her stepmother. "Dad put up with me because I had to be there . . . loved me in his own way . . . gave me just about anything I wanted but we weren't close." Before her seventeenth birthday, Bea dropped out of school and was working as an errand girl for an optical company. One day after yet another row with her stepmother she came home from work to find her trunk and suitcase packed on the front porch. She went to live with the family of a boy she was dating. He was overseas in the marines and shortly after she had left home he was killed. Soon after that she met her first husband. They dated for less than

two months before they were married. "I married to get a home" she said.

Bea's first husband turned out to be alcoholic. He was never abusive but he would binge on the weekends and when he was drunk he would talk constantly. They had three children, two girls and a boy. Her husband would not let her work. Looking back, she says, "If I had been working . . . doing something . . . been around other people, I might not have had to go on Valium."

Bea's first contact with Valium was in 1964 when her youngest child was sixteen. She was taken to a hospital with a miscarriage and the doctor gave her Valium to calm her down, and help her to relax. Apparently, this was a one-time use of the drug with no immediate subsequent use after she left the hospital. She returned home and life went on with the usual "normal stresses" of rearing three teenagers and coping with an alcoholic husband. Then in the early seventies her daughter's marriage broke up and her grandson came to live with them. Bea's husband was out of work and drinking more consistently and heavily. Bea, not aware of any help for spouses of alcoholics, ". . . just thought it was something (she) just had to put up with." Then as Bea tells it, "One afternoon the kids started picking on my grandson and I went out . . . and I mean . . . I just came unglued . . . I don't know what I did or what I said . . . I just lost control . . . they said I called my

neighbor everything I could lay my tongue to . . . which is a thing I would never do . . . and my daughter came and picked me up and they called the doctor." The result of that visit to the doctor was a prescription for Valium which read 10 miligrams--two to four times a day as needed. "Needless to say, the more I took the more I needed" said Bea. The Valium relaxed her and made her feel that "everything was fine . . . take a pill and your troubles go away. It helped me to cope . . . times I'd be so up I'd take none . . . kept my prescription filled so when I had to go back on them they were always available." Bea had no other help to cope with family problems. She says, "I had no idea they were habit forming. A friend, a nurse, said they, were habit-forming but I said, 'I can go off them any time.' I'd go off, be feeling great . . . then I'd get to feeling bad, get depressed, have crying spells; I didn't think it related to withdrawal . . . blamed it on my husband. If he didn't drink so much I wouldn't feel so bad."

Then in 1977 Bea's husband died suddenly. He had come home early from work with what seemed like flu and was watching television. At some point he lay down on the floor and fell asleep. He turned over in his sleep and gasped. Realizing something was wrong, Bea called the paramedics but just as they walked in he gasped a second time and died in her arms. Bea does not remember the funeral because the doctor gave her some shots and she was so heavily sedated

she did not know what was going on. After the funeral she redecorated the house and stayed at home. But the loneliness was overpowering and after two months looked for and got a job in a plastics manufacturing industry. At this time her younger daughter and her two grandchildren were living with Bea, but the children were getting on her nerves and she moved to an apartment, then to another and another but nothing assuaged her loneliness. Then she met her present husband whose wife had just died. They dated for a few months and when he asked her to marry him she agreed. "I was so lonely," she said, "I felt like there was nothing going for me." Her new husband Bill had a teenage son who had resented the relationship from the start. After the marriage, conflict with the son increased to a point where both she and her husband went to a psychological counseling center. There Bea received hypnotherapy in which she went back to her childhood experiences, but nothing was done about her current situation. In the meantime, the Valium which she was still taking had lost its effectiveness and her doctor switched her to Librium which made her feel dizzy so she discontinued its use, though she still kept the pills until, under her therapist's prompting, she threw them out. Then she returned to the doctor who had first prescribed Valium and he continued to write prescriptions for her. By then Bill was taking Valium too. She would take more and more until she could cope and then stop taking it and store up her supply until

she needed it again. "It got to a point where I couldn't do anything--not even make a business telephone call--only way I could get my courage up was take a pill. I would take a pill in the morning and get the boy off to school . . . then a couple to get out to work in the afternoon . . . a couple during the work shift to get through . . . then there would be four pills to get me to sleep when I got home at 1:00 a.m." She was getting more and more depressed. She was even becoming irritable at work where she had been happy. During the day at work she would think of how she might kill herself . . . sitting there feeding the plastics machine and day-dreaming about suicide.

May 10, 1980 Bea had been to the doctor's office for her usual monthly hormone shot. Usually she would feel better after the shot but on Monday May 12 she was feeling really depressed. She picked up her supply of Valium at the drugstore. Then she called the nurse at the doctor's office to report that the shot was not helping. The nurse asked if she was still taking Valium. Bea said that she was and the nurse said, "Don't take anymore until I talk to the doctor." When the nurse called back she got a busy signal, the phone was off the hook and Bea was asleep--overdosed on Valium.

For Bea that overdose was the "bottomming out" event. Two days later she was, on recommendation of her doctor admitted to a local alcoholism treatment center which also treated drug dependencies.

The way back was slow. For a week, Bea did not know what was happening; she just slept and slept for the first two weeks. She was told later that she had 3,625 units of Valium in her system; it took forty days to get the level down to 50 units. Withdrawal was long and difficult. She was very depressed and cried a lot. She had hot flashes, a crawling sensation under the skin of her scalp, hallucinations. Even six weeks after her last dosage of Valium Bea was still suffering from acute anxiety attacks.

What helped Bea most in recovery was the women's group at the hospital. There she could identify with others who shared some of her experiences. "I had thought that everyone else's life was perfect," she said. Now she discovered that many of her problems were life-problems which other women experienced too. She was no longer alone and isolated. During the worst part of withdrawal a counselor who was a recovering drug addict was of great help. He really understood what she was experiencing. "It was like being in a dark tunnel and he was the light at the end." If he could come through so could she. Learning to cope without Valium was difficult. In the beginning of recovery Bea says, "I'd have gone back if I could have got it (Valium) just for relief." Reading the Bible helped, particularly the New Testament helped her to relax. "I don't always remember what I read; sometimes I read the words two or three times." The words Jesus spoke were the

most reassuring for her. Bea and her husband learned to communicate; to talk things out and that too has been helpful in reducing pressure and stress.

As for the future, Bea wants to watch her grandchildren grow up. She enjoys knitting. She has started attending a Catholic church where she and her husband are working towards full membership when the marriage can be validated in the Church.

Salient Features of Bea's Story

1. Unnurtured childhood
2. Abused child
3. Unrootedness
4. Distant relationship with Father
5. Alcoholic husband
6. Need for a home and loneliness strong motivations in marriage
7. Initial non-dependent use of prescribed drug
8. Repressed emotions, anger, grief
9. Over-investment in nurturing role
10. Isolation before and during dependency
11. Denial
12. Drug-dependency symptoms perceived to be psychological-emotional problems
13. Helpfulness of identifying with peers in recovery

14. Being understood by someone who was through dependency and had recovered
15. Desire for full affiliation with faith community

Joan's Story

"I never thought I had a choice" said Joan of the thirty some times she and her family moved in twenty-six years of marriage. Her first introduction to prescribed drugs began in another situation in which she also thought she had no other choice. Joan had just had her second child and returned from the hospital to her home to find her husband's twelve-year-old daughter had come to live with them. She had been in trouble in school and wasn't getting on with her mother. From the start Joan describes it, "She was very resentful of me. I was the wicked stepmother as I recall . . . as I was referred to by her mother." Joan was twenty-three at the time. She had been married three years and had no experience of dealing with a bitter and rebellious teenager. In fact, she herself had been "a good girl." It was unthinkable that she would be anything else in her very strict family ruled by a mother she remembers to have been very domineering, self-centered and complaining, and a father who was strict and distant. The family had been traditional and active members of a fundamentalist religion. Joan's

social life was all within the Church and it was strict . . . lots of don'ts, no makeup, no dancing, no alcohol.

Before the year was out Joan was depressed, sleepless and worn-out handling the constant conflicts with her stepdaughter and the needs of a two-year old and an infant while her husband worked sixteen to twenty hours a day. There was no one to talk to so she went to a doctor who gave her what she then thought was a tranquilizer, Placidyl. "I didn't know about tranquilizers, I didn't know the name of any of them. I just knew that I was a wreck." Joan took Placidyl for two and a half years until her stepdaughter moved back to her mother. Her youngest child was two and a half years old. She went to work. "It seemed that I had more control over my life. There was more contact with people at work; I was happier with my life." In '67 another daughter was born. In the summer of '70 when the family was returning from a family reunion they stopped in Kansas to look around in some antique stores. Joan went into one and her husband went into another. When they emerged and met he told her he had bought the store he had just been in. Before that year was out they were moving again. Joan said, "I was hurt . . . yes angry but anger wasn't something you showed. I didn't know how to handle it. It didn't look very good, feel very good. It was important that I make him happy." Joan's mother had been self-centered and domineering. She knew she did not want to be like her; neither did she want

to be like her husband's first wife. No other models were available. She had seen couples in her church who seemed to be happy but she did not know enough about them to discover how they related to one another. "When we got married it really was important for me to show him that I cared for him. I could have taken care of myself . . . that wasn't what I wanted. I cared so much for him, when we first married . . . it was so important for me to show this man that he could be happy. I forgot about making me happy. We made three trips that summer. We went back in a car without air conditioning . . . we stayed there four months . . . was all, before we came back to California." Then Joan went to a doctor and asked for tranquilizers. Reminiscing, she says, ". . . it has been a lot of years . . . I always felt rootless . . . we always made good money but always a feast or famine . . . but never that cottage with the picket fence . . . that was always my basic thing. The tranquilizer helped, it worked in five minutes, quick. I could still function, the kids were always taken care of . . . I could lie down and rest. I didn't take one to go to bed; I took them to keep going. I have always just taken what was prescribed."

The family spent Christmas with Joan's folks in California and then in the new year they went to visit friends in Las Vegas. Again the husband suddenly decided that they would settle there. Las Vegas was a difficult

place to bring up children. The schools were rough. Her son was beaten up. Her daughter's teacher went berserk at lunch in the student cafeteria and started shooting and killed the principal. The husband was finally convinced that Las Vegas wasn't a good place to live and again they were on the road back to California.

"There was no way out . . . no way out." Joan got a supply of Placidyl from her doctor to see her back to Santa Barbara. She was to need it. During her stay in Santa Barbara, her oldest daughter, still disturbed by her experience in Las Vegas, became rebellious and difficult to handle. Her problems culminated in a pregnancy and marriage to the eighteen-year-old father of her child. The daughter was sixteen. Joan was glad to move again when the next exodus came up. Her daughter's marriage was becoming more and more unhappy. It was better not to be too close to what was happening. "I just felt so torn up" she said.

So they moved again but "nothing changed so far as my emotions were concerned; I was just changing location." Joan saw a doctor who gave her Valium instead of Placidyl, because "Valium was safer." The Valium saw her through her daughter's stormy divorce which followed physical abuse and continuing threats by her daughter's husband. 1978 was a redletter year. Joan's youngest daughter met with a serious accident . . . Joan was called at work, picked her daughter up at the scene of the accident and took her to hospital.

Later in the year after Joan had minor surgery her step-daughter was found to have cancer and began a series of stays in hospital which terminated in her death. Her husband would insist that Joan visit his daughter with him each time he went to see her. These visits were very difficult because Joan was forced to meet the girl's mother and to experience over and over again the hostility from both mother and daughter. Joan says, "I would plead and beg but would always end up going." After one particularly difficult visit her husband suggested that they buy a bottle of wine for dinner. Joan had not cared particularly for alcohol, and she was taking tranquilizers. However, she allowed herself to be persuaded to drink the wine. The alcohol worked like a charm. She never felt better.

Finally the daughter died. Joan attended the funeral feeling like an outsider while her husband and his former wife grieved together. "I was a spectator," she said. After the funeral Joan went home to assuage herself with Valium and her new found friend alcohol. For two weeks she "drank everything in sight." Then one day she saw an advertisement for an alcohol clinic. She says "I just knew I had to do something about the drinking." She arranged to check in to the clinic and though her husband tried to dissuade her, ("We can lick it ourselves") she did. Joan says, "I didn't care what anyone thought anymore. I had to take care of me."

Getting off the alcohol was easy, she said, but there was more to come. She felt well until the Valium began to wear off. She was back at home when the withdrawal hit. This time her husband who knew all along about the hazards of Valium told her about a local hospital where persons were treated for Valium dependency. She went to the hospital and went through the recovery there. Joan is grateful for her dependency--it opened up a new world for her--she sees now that she has a responsibility to herself and she is willing to displease her husband if necessary to take care of herself. Joan doesn't have dreams for her future except to go on paying attention to her needs. She attends AA and Pills Anonymous and works as a volunteer in an alcoholism unit in a hospital.

Salient Features of Jean's Story

1. Strict, moralistic family background
2. Over-investment in nurturing others
3. Stereotypical notion of "wife's role"
4. Unrootedness in married life
5. Unresolved grief
6. Stress from sole responsibility for parenting
7. Inability to demand that her needs be considered in marriage relationship
8. Husband's workaholism

9. Repression of feelings
10. Fear to risk testing the marriage relationship
11. Ethic of the drug culture--there's a pill to fix everything--instant relief
12. Ignorance of the hazards of prolonged use of drugs
13. Blind trust in doctors
14. Lack of alternative ways to deal with life-problems
15. Failure to find support in church

Ellen's Story

Ellen was twenty-eight, married to an alcoholic and drug abusing husband (who abused her physically and verbally) whom she had married to get away from home. Her father was an alcoholic. She had been reared in the Catholic Church but she had never received any help from the church to deal with the alcoholism problems in her family of origin or in her marriage. Her marriage at eighteen to a Baptist had left her estranged from the Church and under the disapproval of her family. Soon she developed severe pain in her back and shoulders and finding no physical cause, the doctor diagnosed tension and prescribed Valium. The prescription read "Valium, five mg., one to three times a day." By the end of three years she was taking ten mg. several times a

day and as she says, was hooked. And the Valium helped. She was more relaxed, she could overlook her problems. She did not cry so much or complain. She did not dread her husband's homecoming so much any more.

But problems escalated as the children reached teen years and began using drugs. By then Ellen had been on Valium between four and five years. One evening her husband came home drunk and combative. They had an argument; everything seemed hopeless. Ellen wanted to end her life and took an overdose. She was taken to an emergency room, recovered and returned home. Her mother came to stay a while and took her to a charismatic prayer meeting at a local Catholic Church. That helped; there was warmth and sharing. She could express her feelings in prayer. Her husband sought help with his drinking problem and was admitted to a hospital alcoholism treatment center. The treatment involved the family and this is how Ellen's chemical dependency was discovered. She agreed to being admitted to the same program as her husband.

At first Ellen was angry with the doctor who prescribed the Valium in the first place. Then she realized that she had to turn her energies towards recovery. Withdrawal brought a host of problems, sleeplessness, depression, confusion. She had difficulty minding her money. Many of these symptoms lasted for about three months. Coping without Valium was frightening. The neck pain returned. A paper

which she received at the hospital helped her to handle chronic pain. She learned to express her feelings. She no longer "acted happy" but cried when she needed to. Sometimes she would talk to herself in the mirror to get her feelings out. She became a member of the Baptist Church because the Catholic Church in the town to which she had moved seemed cold and distant. Ellen's husband stopped drinking but continued to take drugs. She decided on a separation. This was a frightening move because she had become dependent on her husband for financial support.

Now she has a job she likes and is managing to cope financially. She has regained a new self-confidence in place of the pseudo-confidence which the Valium gave. Her children have moved out of the home and are both taking drugs. Though she does not approve of their life-style, she is able to accept it and maintain a fairly positive relationship with them. Ellen says, "Finally I am taking care of myself; I used to think it was selfish to take care of myself but my children like me better now."

Assessing what helped her most in recovery and rehabilitation, Ellen mentions a counselor who had abused drugs and understood what she was experiencing. She also finds great support in her church and cites the fellowship she experiences there as most helpful. She finds support in her faith in God and says that she can leave the unsolvable problems of her life "in God's hands."

Ellen hopes that in the future she and her husband will be able to get back together again if he will make some positive changes in his life, but she "wants a husband, not another kid." The future will be good, she says because she is happy and there are more possibilities.

Salient Features In Ellen's Story

1. Alcoholic family of origin and alcoholic husband
2. Physical abuse in the marriage
3. Insufficient nurturing in childhood
4. Alienation from family and Church during early years of marriage
5. Drug prescribed for psychosomatic symptoms
6. Tensions arising from inability to control children and an unequal share of parenting
7. Inadequate expression of feelings
8. Feeling trapped
9. Suicide attempt
10. Need for warmth and relatedness in Church community
11. Ignorance of the hazards of the drug
12. Denial of the dependency

Doris' Story

"I just felt that if I took another pill I would die." said Doris. That was a few days before Christmas 1978. She had been taking various psychoactive drugs since 1963. Doris suffers from a degenerative spine disease which she has had since the age of thirteen.

Growing up the daughter of a Baptist minister was difficult, trying to live up to the image of the ideal minister's daughter. There were lots of don'ts. The family motto was never quit. There was little emotional warmth in those days. At the age of nineteen Doris married a serviceman. He was an alcoholic and in the six years of their marriage they were together for approximately two. Doris describes her first husband as a mean alcoholic who abused her physically. In 1959 she left her husband and got a divorce. She had custody of their two children whom she supported by working in a bank. There was considerable financial strain. Doris remarried in 1959 to her present husband with whom she has two children, the youngest, eighteen years old still lives at home.

In 1963 Doris had back surgery. Her doctor prescribed Librium, 5 mg. every four hours and codine. She continued to take the Librium under the doctor's direction for the next five years and during that time the dosage was increased to 10 mg every four hours. The Librium helped her back, relaxed

her and lessened the back spasms. Her doctor had told her that Librium was not addictive and she did not worry about it. At some point in the sixties the doctor switched her to Valium which had come on the market and was touted as the wonder drug. By the end of the sixties she was taking about 150 mg. of Valium plus codine. By that time she was vaguely aware that there was something wrong; if she didn't have the drug, for instance if there was a delay in getting her prescription filled, she would panic.

As time went on into the seventies the Valium became less effective so the doctor kept adding other drugs. Doris remembers Chymoral, Dalmane, Norgesic. Of the last years of the decade Doris does not remember much. She was "out of it" most of the time, sleeping a lot. Her marriage was close to dissolving. She had no friends, was isolated at home.

Then came that day in December 1979 when with a flash of realization accompanied by fury at what was happening to her, Doris quit, just like that . . . cold turkey. Looking back now she says she was stupid, but she had no other recourse and didn't know about massive withdrawal. She was soon to learn about it. Soon she was having "the shakes, muscle cramps, nausea, and by the twelfth day, withdrawal was hitting her full force and she was convulsing." The doctor who had prescribed the drugs did not return her call. He had been disbarred from practicing because of

irresponsible prescribing of drugs. No one else would help. "No one wanted anything to do with it."

In desperation, Hal (her husband) called a local pain control center which referred her to an alcoholism and drug dependency treatment center at a hospital near by. Doris checked in. The first relief was to hear from the female doctor there that her problem was physical, not mental and that she could be helped. Doris was hospitalized a total of ninety days in three phases. She was in thirty days and out a month. She went back because she couldn't walk. Again she was in thirty days and out three weeks, concluding with a final thirty days in the treatment center. Altogether, it took eleven and a half months for her to recover from the more serious physical and emotional results of her dependency. During the summer of 1980 while she was receiving out patient care Doris' sister, an alcoholic, committed suicide. That was a shattering blow but with the help of the staff and friends she had made at the hospital she weathered it. She is still not through grieving she says. Asked what was most helpful in the treatment program she says, "Dr. Sands. She knew what I was going through, she understood and she could help."

Doris does not attend any support or self-help group. She has many friends both at work and elsewhere. She enjoys bingo. She holds a full-time job at a restaurant and loves the work. When asked how she handles back pain now without

drugs she says "I ignore it and it goes away." She does not feel that she is to blame for the development of the dependency. She is still angry with the doctor who prescribed the drugs. As a result of counseling in the hospital she has talked many things out with her mother. They have a warm relationship. She explains her mother's present warmth as opposed to her stern distance when Doris was young saying, "Since Father died she has recovered from being a minister's wife." Doris approves of some feminist values like equal pay for equal work, but she doesn't like the idea of calling a man up and asking for a date. "Maybe that's all right for the younger generation," she says.

Doris says that she is happy. Every day looks good. Her marriage is stable again. As for church and religion, she is not interested. Her earlier experience was too negative. She has God in her heart and that is enough for her.

Salient Features in Doris' Story

1. Drugs prescribed for physical pain
2. Moralistic religious and home background
3. Living up to ideal image of minister's daughter
4. Distant relationship with parents
5. Alcoholic first marriage
6. Medical-drug culture
7. Irresponsibility of Doctor

8. Ignorance of hazards of drug use--blind trust in doctor
9. Assuming withdrawal symptoms were sign she was going crazy--relief when they were explained as result of medication
10. Anger with prescribing doctor
11. Isolation during period of drug dependence
12. Establishment and/or restoration of relationship with others in recovery
13. Feeling no need for on-going self-help group
14. Mostly traditional values regarding role of women
15. Alienation for established religion but personal inner religion

Marilee's Story

Marilee had had a history of back problems. In 1960 she had a spinal fusion. In 1970 the pain recurred and became very severe until in 1972 the doctor gave her Valium--a shot and a prescription for five mg. every four hours. The Valium was a God-send, Marilee said. Now she could cope. And it helped her cope with her marriage too. She had married at seventeen "to get away from home." She remembers home as a place where she was scared to death. Her father was very strict. She had no say in anything. Her mother

was always on pills. Her marriage wasn't the escape she had hoped for, however. Her husband was an alcoholic who abused her verbally and emotionally. The marriage lasted twenty-eight years and there were three children. She went through a divorce in 1978.

Marilee took the Valium according to the prescription for eight years until in 1980 she read an article about the adverse effects of the drug. Frightened, she tried to withdraw herself but the withdrawal symptoms were overpowering. She could not sleep, was losing control of the car when driving, her body felt numb. She called a doctor who referred her to a doctor at the local drug dependency treatment center.

Marilee spent six weeks in the center undergoing detoxification, education on chemical dependency and therapy-individual and group. Two weeks after she was discharged she started to drink and returned to the hospital for a further two weeks. Of this episode she says, "I came out too soon. I wasn't ready. I was just scared to face life without the pills." During her short second stay in the hospital she said, "It was just like a light went on in my head. I knew I could, with help cope without them." Since then she has been staying drug-free with the help of Pills Anonymous and Alanon which she attends to deal with her son's alcoholism. In these groups she finds support, communication and caring. Marilee has no negative reactions to her experience in her church. She found the pastor

supportive, especially during her divorce. However, she did not get any help there in dealing with her drug problem or with the alcoholism in her family.

Salient Features in Marilee's Story

1. Alcoholism in her family, mother's use of pills
2. Strict upbringing-fear ridden
3. Valium prescribed for physical pain
4. Did not increase the dosage or abuse the drug
5. Drinking after release from hospital

Linda's Story

"You learn to dress to hide marks" said Linda. She is explaining why, when she was a child, teachers never noticed that she had been beaten and abused. Linda married at seventeen to get away from an alcoholic home. Her marriage was reasonably happy. She and Bart had three children. She does well as a parent she says. She had plenty of practice taking care of her three younger brothers. She did not know how to take care of herself, however. In fact it's hard for her even yet to believe that anyone would care about her. Her parents didn't; why would anyone else?

Three and a half years ago Linda had neurosurgery. She had an unusual reaction to the anasthetic and to whatever

other drugs she was given before the surgery. As a result she had hallucinations. She could hear satanic music, she saw her daughter commit suicide. She pulled out her iv. and one half of her body watched the other half walk to the door to call a nurse. As a result she was afraid to go to sleep even when she had recovered from the reaction. Before leaving the hospital she was prescribed Valium, 5 mg., one or two, as needed, for sleep. And they helped. She could sleep. Next time she needed a prescription she asked for 10 mg. tablets--one ten was the same as two fives, she reasoned. Soon one ten wasn't enough and she took two tens. A friend who knew a pharmaceutical salesman got her two or three 1000 tablet bottles. Gradually, Linda was taking her "sleeping pills" earlier and earlier. She would wake up during the night and take more. She lost track of how many she was taking. "I thought I was going crazy; I was afraid to answer the phone or the door." Her adult children thought she was drinking.

"Finally" Linda says, "I couldn't handle being crazy so I went to a psychiatrist. I told her all about the pills." The psychiatrist sent her to the local drug treatment center. The first five days she was gradually taken off the Valium. Her withdrawal reactions were severe. She was nauseated, had muscle spasm, she shook inside a lot, she had bad headaches and there were black spots rushing at her in front of her eyes. Linda said "I was scared but I could see the end

of it. One of the hardest things was to believe that the staff cared; "I didn't deserve it." She felt ashamed and guilty. While she was taking the drug she had read I'm Dancing as Fast as I Can but didn't make the connection with herself. Yet she had gone to the psychiatrist intending to tell her about the pills.

By the time Linda left the hospital she had severed all ties with her pill suppliers. Linda is still in the earlier stages of recovery. She attends a women's group at the hospital where she is slowly working through the pain of her battered, unnurtured childhood. She does volunteer work at the hospital, but she says she gets a lot out of it herself. "I come here for me." She has four or five really good friends. She wants to make things all right for her youngest son who is fifteen. He is the one most affected by her bout with drugs. Linda says that her future looks better than the past three years. She has no plans or dreams for the future because she has still to work through left-over business from the past. "Right now I'm taking care of me."

A major issue with Linda is her religious beliefs. She gave up believing in God because she could not believe in a god who would permit what happened to her as a child. She would like to be able to believe . . . "but not hell and damnation . . . my suffering that was hell enough."

Salient Features of Linda's Story

1. Battered child
2. Insufficient nurturing in childhood
3. Parenting role at an early age
4. Illicit source of drugs
5. Isolation--resulting from dependency
6. Denial
7. Low self-esteem
8. Unresolved issues from childhood and family of origin
9. Faith crisis because of suffering
10. Rejection of moralistic religion
11. Desire for a spiritual life

Margaret's Story

Margaret is a nurse but she isn't practicing. She lost her license for the second time in 1980. A few days previously she had checked into a drug treatment center.

Margaret's childhood and adolescence were happy. She remembers a creative and gentle father who died when she was nineteen. "I was wanted, loved, and cared for." she says. Her parents' message was "No matter what, you can cope; everything will always work out." And it did. There were no problems in the first seventeen years of her life--no

family illnesses, no deaths. There was alcoholism in the family; both maternal grandparents and two uncles were functioning alcoholics. She wasn't aware of that as a problem when she was growing up but she was surrounded by alcoholics. She does know that she was afraid of drunkenness. Margaret was imaginative and up until she was twelve had a fantasy world in which her people were as real as actual people.

After high school she went into nursing school. She loved nursing, but when a patient to whom she had become attached died after heart surgery, she fell apart. At that time there was not much awareness of the phenomenon of grief, and her nursing supervisor didn't know how to help her cope; she was simply told she should take six months off. She dropped out of nursing school. That was the first failure of her life and she was to regret that decision for many years. Then followed a series of deaths in the family, her grandparents, an uncle. Two family pets died. A couple of weeks after her grandmother's death her father was diagnosed as terminally ill. It seemed that there was just too much grief to bear. Moreover she had fallen in love for the first time. "You can't feel this if you're in love," she thought; so Margaret did what she was to do habitually with painful feelings; she "stuffed them all down."

Margaret married at the age of nineteen. By that time she was pregnant, but she and Ray had been engaged

before she became pregnant so the marriage was not a consequence of the pregnancy. A few months later her father died. Both she and Ray loved children. Parenting was their greatest strength. Four children were born in the first five years of marriage. Margaret recalls that, as was the custom then, she was given sleeping pills in the later stages of pregnancy to make her comfortable at night, Demerol before delivery and pain pills afterwards. But there was no obsession with drugs at that time. Taking them was routine and when she was through the birth she did not think of them again. In the beginnings of the marriage, they were poor and Margaret experienced limits for the first time. The earlier married years were relatively happy though a sense of dissatisfaction led Margaret to see a marriage counselor--not that their marriage was in trouble . . . she just thought there should be something more.

In order to augment their meager income, Margaret began taking in foster children. The work was hard but she enjoyed it until she became tired of having to give the babies back. Then Margaret decided that she wanted another baby of her own. She and Ray tried (though Ray had some resistance to having another child) and there were three miscarriages within a year. Margaret's grief over the miscarriages was great but there was no opportunity to mourn. Then finally she got pregnant again and this time

carried a girl-baby to full term. When the baby was born she was triumphant and happy. But they were in debt.

By the time the baby was about a year old, Margaret had seen her through menengitis, had had a hysterectomy and had taken a job at a hospital working nights and taking care of the children during the day. She loved the work and did not feel overburdened with all she had to do. In the meantime Ray had begun to have severe headaches. Margaret noticed that drugs were frequently left over in vials at the hospital and discarded. She began bringing them home thinking they might be useful for Ray or someone. She does not recall intending to take them herself and she did not take any because at that time she did not feel the need for them. It wasn't stealing because they were being thrown out anyhow, she rationalized. During this period, she discovered that Ray was having an affair with her sister-in-law. There was a lot of anger and recrimination. Eventually the storm passed and life went on as usual, but walls were going up between her and Ray. He was having headaches three or four times a week. He would cry when she left for work and call her several times during the night. He began to see a psychiatrist who sent him to a psychiatric hospital, where he was given shock therapy.

One day Ray's psychiatrist summoned Margaret to a meeting and issued an ultimatum. "Ray cannot handle your working any more; you'll have to quit." "I was so angry,"

Margaret said, "I loved work; it was a whole new thing . . . getting out with people when I had been locked in with kids for thirteen years. And there was that doctor saying, 'You have to quit.'" She quit. In a month's time she had the first real depression in her life. Inside she felt bitter and angry but she did not know it was anger then. "I just felt, what's the use." The same psychiatrist put her in hospital and gave her shock treatment. "I was terrified . . . afterwards I didn't know anyone or anything. There was no therapy." Margaret left the hospital worse than when she went in. The doctor was angry; she hadn't responded. He said that she must be a manic-depressive and gave her Lithium. Then one day she woke up and the depression was gone. Margaret says the recovery couldn't have been the Lithium; she had only been on it three weeks. Maybe it was her natural resiliance. Margaret recalls that at some time during these years she made her first suicide attempt after a row with a friend. She felt utterly rejected and decided to kill herself by taking six sleeping tablets. Another time she took off in the car without telling her family where she was.

The gap between her and Ray was widening; he was working seven days a week. He was drinking heavily. "I threw him out a few times." she said. Finally she told him not to come back, packed his case and left it off at his place of work. Ray called that night drunk and passed out

on the phone. She traced him to a motel room and found him in a coma, overdosed on valium and alcohol. He was taken to emergency and they pulled him through. His psychiatrist, angry with him this time told Margaret to go back to work. She did, as a nurses' aid in a hospital. This was the happiest period in her adult life. She was appreciated, good at her work. At her supervisor's persuasion she went back to nursing school.

This was a difficult time financially. Ray got a better job but Margaret was working only a few days a week and going to school. But they had a dream. When she would get her R.N. they would sell the house and move to the beach. Then Ray became ill with what turned out to be chemical pneumonia. The night of her pre-graduation party he came home and said he could not go. Margaret was furious. She had looked forward so much to that party. She went alone, got drunk and stole from her host's stash of drugs in the medicine cabinet. She went home and fell asleep. Ray went through her purse and found the pills. There was another row followed by Margaret's attempted suicide, this time an overdose of Nembutal.

But Margaret got the State Board Exams and became an R.N. She began working round the clock. Headaches and colitus developed. She was seeing two doctors and taking Tylenol and codine as well as Dalmane for sleep. Ray lost his job and sued the company for damages. It was during

this time that Margaret stole controlled drugs for the first time. There was morphine around, left over in vials. Just out of curiosity one day she injected herself. That was a beginning. Soon she was shooting morphine once a week, then twice a week . . . hiding the injection marks. Ray's settlement came through and they went to Hawaii taking a satchel of prescription drugs along. For twelve days they lived high on alcohol and drugs. Then back to the hospital, still functional and on good terms with staff and doctors. Every day she told herself, "I have to quit." One day she forgot to log a patient's drugs and the patient was medicated a second time by another nurse. Her supervisor began to watch her. In less than a month she was apprehended for theft and drug abuse and criminal charges were filed.

Margaret thought of killing herself but her counselor at a family service talked her into telling her family instead. Ray was supportive. After Christmas Margaret became depressed and was hospitalized. There she got psychotherapy and worked through some grief but no one did anything about her drug problem. In hospital she was given all kinds of drugs except narcotics. Discharged from hospital Margaret was hired again and went through a hearing before the medical board. She was stealing pills, seeing a psychiatrist and getting Valium from a doctor. Then her license was revoked. That brought on her third suicide attempt.

This time she was given rational emotive therapy. Somehow she became convinced that suicide wasn't the answer. She got the idea that she was savable and that if she were dead there would be no more possibility of getting out of the net. Still nothing was resolved with Ray. She went to work as a mental health nurse. It looked like she had it all together and, encouraged, she went before the board and got her license back. She went back to medical nursing . . . now drug free for four or five months but she had a sense that she would relapse. The oldest son dropped out of college addicted to drugs. She and Ray went to see a therapist to get help for their son. Ray and she separated again but continued to see the therapist. Then Margaret discovered a breast tumor, surgery followed, Ray came home but the reunion lasted only three weeks. They filed for divorce. Margaret developed severe headaches and a tumor was suspected. She was put on Talwin. Thinking that their marriage was over, Ray told her that he had had a series of affairs in the past sixteen years. Margaret was shattered and became depressed. A psychiatrist put her on Nardil. She began stealing drugs again at the hospital. Once more she was caught. This time she ran. She went to Las Vegas, changed the color of her hair and changed her name. Finally she called home and returned. By now she was hooked on Talwin. Once again she was hired by a hospital. Her headaches continued and after she had had a months leave of

absence owing to an eye accident she was forced to resign. For a while she worked as a private duty nurse. She had gotten used to Ray's being gone and she was making a lot of money. Life was easier and she was on friendly terms with Ray. After the two had spent four days together experimenting with Talwin Ray decided to return home. Nothing was really resolved between them and soon conflict began again. Margaret was working nights, and hated her job and once again she was discharged. Margaret's headaches were continuing and a doctor finally diagnosed her problem as sinus blockage. He recommended and performed surgery.

Around this time a series of family crises occurred. Margaret's daughter had a serious automobile accident, her brother died suddenly. She needed more Talwin as tolerance built up, but it was getting harder to obtain the drug. Withdrawal symptoms were making it increasingly difficult for her to cope at work. Margaret had the remedy stored in her memory, however. In the Spring of 1980, she had heard a doctor speak on the addictive properties of Talwin. (That was the first time she had heard that this drug is addictive.) From then on she knew that she could, if the worst came, call that doctor. By June the worst had come. Margaret phoned the hospital where the doctor headed an alcoholism and chemical dependency unit and asked to be admitted. A short time after she was admitted, Margaret lost her license again.

During her stay in the treatment program Ray who had been taking part in the couple therapy which was part of the program decided to check himself in also. Margaret went through the entire program and has remained drug-free in the two years since. She attends a drug-dependency group for nurses and goes to A.A. Currently she is working on getting her license back. Since they have become drug-free Ray and her get on better together. There's more honesty, she says and they can talk out their differences. Life is better.

Salient Features of Margaret's Story

1. Her early tolerance of drugs
2. Alcoholism in her family
3. Repression of grief and anger
4. Unpreparedness to cope with difficulties, stress, opposition in life
5. Coinciding crises in her life . . . number of deaths in a short space of time, four births in five years
6. The medical-drug ethic of the '50's, '60's, '70's--the doctor can fix it, the drug can fix it
7. The patriarchal sexism of psychiatry--the psychiatrist dictated when and if she should work outside the home

8. The physical on-slaught on her body--frequent pregnancies, miscarriages, hysterectomy, breast surgery, sinus surgery, bladder surgery, shock treatment
9. Combination of tendency to involve herself in stressful situations and inability to cope with stress
10. Tendency to nurture others--to enjoy nurturing but inability to defend her right to receive nurturance
11. Undervaluing self because she did not fit the cultural feminine stereotype
12. The availability of drugs
13. Awareness of God . . . somehow always there, combined with feeling unworthy "God didn't leave me, I left God"

Analysis of Womens' Stories

For the purpose of understanding variations in the etiology of prescription drug dependency I have divided the seven women's stories into four groups. Bea, Joan and Ellen were long-time users of the psychotropic drug for mainly emotional problems arising from their life-situation; Doris and Marilee used prescribed drugs primarily to manage physical pain; Linda is placed in a separate category because it

seems that the drug was used originally to keep an emerging awareness of the effects of her battered childhood from surfacing in a way that she could not deal with; and finally Margaret is in a separate category because unlike the other women she began experimenting with drugs mainly for the pleasure they gave (for kicks) though in her case they also helped her to cope with repressed anger and frustration.

There is a popular notion that people use drugs to escape from life's problems or for pleasure. This motivation may well be primary in adolescent experimenters or in adult street-drug users. However from the stories of these women it would seem that six of them used drugs to cope. They discovered when they began to use the drug that it had other benefits as well--it helped them to relax, they felt good. Possibly it gave them an initial sense of invulnerability--for a while nothing "got to them." This sense of invulnerability is more operative for persons like Bea, Joan and Ellen who took the drug to cope with emotional pain. For persons like Doris and Marilee the drug lessened the physical pain so that it became more bearable, but it did not eliminate it. It is of interest to note that these two women took steps personally to go off the drug which had been prescribed for physical pain. This fact may not be of any significance. However, it may indicate that the denial system of persons who perceive themselves as taking the drug for relief of a physical problem is less entrenched than that of a person

who perceives herself as using the drug for emotional and hedonistic reasons.

Another aspect of dependency on prescribed drugs which may differentiate it from other chemical dependencies is what I will call the mask of medical respectability. It is easy for both the woman and her family to rationalize that she is taking what the doctor prescribed (even when she may be self-medicating) and that the doctor would know if it were harmful. This reasoning may simply have to do with the woman's trust in the infallibility of the medical profession. It may also, however, cover an underlying sense that she is abusing the drug. Bea's defensive answer to a nurse friend who warned her about the hazards of Valium indicates that she had developed a denial system early in the dependency process. Joan, however, seems to have been quite unaware that she had become dependent on Valium; it was her dependency on alcohol (which she knew to be addictive) which led her to seek help. The alcohol problem was rapidly solved, her cooperation with the treatment indicates that her denial was minimal in regard to the alcohol. It was not until she was clear of alcohol and the Valium withdrawal set in that she sought help for her Valium dependency. There is some indication here that she honestly did not know that she was addicted to Valium. Margaret had a complicated denial system in which the medical board, her psychiatrist, her family colluded. It is almost incomprehensible that she should

have had her nurse's license revoked twice and that the medical board at no time recommended that she receive treatment for drug dependency. Margaret's story indicates that there are special factors operating in the drug dependency of nurses (complex denial, possibility of multiple drug-dependency because of the availability of drugs, guilt because of the criminal nature of the offense) which will differentiate them sharply from other women dependent on legal drugs and which warrant a special study. Moreover, social and vocational rehabilitation of a nurse who has been debarred from practicing requires special attention.

In addition to the fact that it is easy for the family to rationalize that Mom is "under doctor's orders and that they should not interfere," there is another recurring factor in these women's stories. Frequently (in fact in five out of the seven cases) a spouse or other family member was also chemically dependent. The family stake in denial in these instances was particularly high.

In the case of Linda, an underlying but suppressed emotional conflict preceded the drug dependency. It is possible that the anasthetic she received during surgery broke down the barrier between her conscious and unconscious mind and that her hallucinations were similar to nightmares, i.e. symbolic forms of elements in the unresolved conflicts arising from her abused childhood. Her fear of sleep seems to indicate fear that these unconscious memories would become

stirred up again. The Valium helped to bury then again and keep them buried. Now that she is in recovery Linda needs help to deal with these emerging memories and conflicts. The presence of pre-dependency, psychological problems can complicate as well as facilitate getting a person into treatment. A negative factor is that a psychiatrist, rightly detecting these underlying problems may treat them, while failing to recognize the presence of the drug dependency, or even, if recognizing it, assuming that it will disappear when the deeper problems are cleared up. This apparently is what happened when Bea sought help from a counselor. On the other hand, Linda's brush with the terrifying world of her unconscious led her to "think she was going crazy" and to seek help from a psychiatrist. Fortunately, this psychiatrist (a woman) recognized her drug dependency and sent her for treatment. Now apparently she will be able to deal with the underlying emotional conflicts in the on-going group therapy in which she is involved.

Profile of the Drug-Dependent Middle-Aged Woman

The drug-dependent woman is highly invested in nurturing others but unaccustomed to having her needs met or nurturing herself. She is not assertive and tends to repress feelings of hurt and anger. She may have unresolved grief. She is married to an alcoholic or a workaholic spouse and

carries most of the burden of parenting. She has bought into the cultural belief that there is a medical cure for almost everything and she is submissive to doctors and other professional authority figures. She uses the drug of choice to cope with physical and/or emotional pain, anxiety or stress. She may have been abused by her spouse.

She is likely to have come from a strict, cold, unnurturing family. She may have been physically abused as a child. She married in her late teens and may be divorced.

There are, no doubt, many middle-aged women who fit this profile and yet are not dependent on prescribed drugs. To this profile we must add the event of an emotional or physical crisis, a careless or accommodating doctor (usually one with a stereotypical view of women as emotionally weak) in order to have the ingredients of legal drug dependency.

The seven women interviewed for this study represent a small and selective sample of women dependent on prescribed drugs. However, characteristics and behavior which they reveal (low self esteem, rigid moralistic background, marriage to an alcoholic spouse, likelihood of attempted suicide, onset of addiction related to life-crises, tendency to respond to crises by becoming depressed, over-valuing of the female sex role and emotional conflict over making that role work) are also predicated of addicted women in the literature of

chemical dependency and alcoholism.[3] This fact seems to indicate that the sample is more typical than its size and selectivity seems to warrant.

Spiritual Aspects of Drug Dependency

Moralism, the image of God as judgemental and punitive features strongly in the religious background of drug dependent women. They experience a need for unconditional caring and acceptance and a spirituality which gives meaning to their life experience. They have been taught that self love is selfish and have difficulty taking care of themselves without feeling guilty. Shame and guilt go with drug dependency and it is more pronounced in those who first received the drug for emotional rather than physical problems. They can relate better to nondenominational spiritual programs than they can to church related religious services because there they do not have a particular image of God imposed on them. Each is free to seek God as she perceives God to be. The drug-dependent women's need for relatedness makes their sense of alienation from God (because they feel guilty and bad) particularly painful. Finally, because they have been through an experience of spiritual nothingness, of being without an adequate image

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[3]See Anne MacLennan (ed.) Women, Their Use of Alcohol and Other Legal Drugs (Toronto: Addiction Research Foundation of Ontario, 1976), pp. 59-62.

of the self, they have an avid hunger for spiritual wholeness. They are ready to begin a quest for the transcendent. For that reason their recovery program must include opportunities for spiritual growth.

The following is a description of the dependency process based on the foregoing stories.

Dependency Process

I Normal Use: For short-term medical crisis or emotional trauma

II Dependency Stage:

- A. Needing drug periodically for serious but not traumatic life crises
- B. Needing drug for minor crises
- C. Needing drug to get through the day
- D. Running away--may leave the family without warning

III Despair Stage:

- A. Profound withdrawal from social contact
- B. Sleeping a lot--insomnia--anorexia
- C. Suicide attempts, child neglect

IV Recovery Stage:

A. Detoxification

B. Physcal, psychological and spiritual rehabilitation

EXPERIENCE IN FAMILY OF ORIGIN

Name	Alcoholism in Family of Origin	Alcoholic/ Drug Abusing Spouse	Neglected in Childhood	Strict Moralistic Home	Cold Unnurturing Parents	Battered Child	Physical Abuse by Spouse	Warm Nurturing Parents
Bea		X	X		X	X		
Margaret	X	X		X				X
Joan				X	X			
Linda	X		X	X	X	X		
Doris	X	X		X	X			
Marilee		X		X	X			
Ellen	X	X		X	X		X	
	4	5	2	6	6	2	1	1

PRE-DEPENDENCY AND DEPENDENCY EXPERIENCES

Name	Parenting Problems	Grief/Loss	Uprootedness	Isolation From Other Adults	Isolation	Burden of Parenting Laid on Her	Highly Invested in Nurturing Others
Bea	X	X	X	X	X	X	X
Margaret		X					X
Joan	X	X	X	X	X	X	X
Linda					X		X
Doris					X	X	
Marilee					X	X	
Ellen	X				X	X	X
	3	3	2	2	6	5	5

Chapter 3

UNDERSTANDING DEPENDENCY ON PRESCRIBED DRUGS IN WOMEN

Drug dependency is described as the compulsive or destructive use of psychoactive substances which include street drugs, such as heroin or cocaine; prescription drugs, such as Valium, or codeine, over-the-counter drugs, such as sleeping aids, diet pills; and alcohol. Since the study of dependence on prescription drugs is still in its infancy, most of the available research data and clinical experience comes from women who use street drugs or alcohol. However, many experts in the treatment of addiction consider the basic syndrome to be the same regardless of the chemical which is abused. Vernelle Fox says:

> The principles of addiction are quite simple. Pain+Relief=dependency. This is a basic phenomenon common to all of us. No problem, as long as it is a simple physical hunger that is being fed. . . .
>
> For the disorder under discussion (alcoholism) the pain is either physical, or psychological or cultural, but more often than not an intermix of these factors. The relief is a learned experience of self-medication of a given, usually increasing amounts of ethel alcohol with or without other sedative chemicals.1

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[1]Vernelle Fox, M.D., "Substance Abuse: Mechanics and Management" (paper presented to the World Congress of Rehabilitation Medicine, Mexico City, October 1974), p. 1.

However while it would seem that the principles of addiction are similar, regardless of the addicting chemical, there are also some factors associated with dependency on prescribed drugs which are unique to that particular form of addiction and are unique to women addicts. First, I will consider the general features of chemical dependencies and then I will discuss the aspects of that problem which may be unique to dependency on prescribed drugs as it affects women.

Physiological Aspects of Dependency

Drugs have certain properties which interact with properties of the human body to produce results which may or may not be predictable and may or may not be beneficial to the user. Vernelle Fox refers to that unpredictable variable in drug use in her article on substance abuse as follows:

> People who drink sometimes notice that the same amount of alcohol hits them with more of a wallop one day than another. The same phenomenon holds true of other drugs, including many prescription drugs. In effect, you cannot be sure a mood-changing drug that acts one way in your body one day will react the same way the day after. That is so because of a number of factors: the physical and emotional state of the user, previous exposure to other drugs, the pattern of recent use of the same drug, fatigue, and how much of the drug in question has been secreted from the body.2

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2 Ibid., p. 6.

The Process of Dependency

The process of dependency is related to properties of the chosen drug interacting with characteristics of the person. Drugs vary in the rate at which they are secreted from the body. The amount of time which it takes half the original level of a drug to leave the user's system is known as the half-life of the drug. Alcohol has a relatively short half-life; for example the body will usually metabolize the alcohol in a can of beer in about two hours. Other drugs however have a longer half-life. Valium is reported to have a half-life of thirty to sixty hours. The half-life of a drug is also affected by another quality of potentially addictive drugs, tolerance. Tolerance means that the body quickly adjusts to a particular dosage of a drug so that to obtain the same effect, the initial dosage has to be increased. Soon the body becomes used to the higher dosage which in turn has to be increased in order to be effective.[3] This cycle of more requiring still more is a phenomenon which the former pill abusers interviewed described as part of the process of becoming dependent on the drug of choice. Another phenomenon which is related to tolerance is the paradoxical effect of most mind-altering drugs. This effect means that

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[3]Myron Brenton, Women and Abuse of Prescription Drugs (New York: Public Affairs Press, 1982), p. 6.

when the drug wears off, the person does not return to the original pre-medicated state but to a level of more acute distress--more depressed or more anxious. Thus in addition to the need for a higher dosage because of physiological tolerance there is a psychological need for a higher dose because the person's symptoms have become aggravated by the supposed remedy.

Yet another attribute of psychotropic drugs which makes their effect difficult to predict is their "synergistic effect." Joan describes this potentiating effect when she said of her first experience of combining alcohol and Valium. "He (her husband) said, 'Go ahead and take it, you'll feel more comfortable, more relaxed,' and did I ever . . . I hadn't felt so relaxed, I don't think, ever, . . . I mean, just relaxed." Almost all drugs are potentiated when combined with alcohol. Several have a potentiating effect on one another, thereby adding to the risk of overdosing in the case of drug dependent persons who, as their dependency becomes more acute, and their judgment unreliable, tend to mix pills indiscriminately.

Properties of Specific Categories of Drugs

In addition to the general properties of psychotropic drug which cause them to be conducive to dependency, drugs within the specific categories of prescription drugs

have each unique hazards for the dependent user. There are four major kinds of prescribed drugs which women who are drug dependent are likely to take either separately or in combination with one another. These are tranquilizers, sedatives, stimulants, and pain-relievers.

Tranquilizers

Tranquilizers were first introduced in the early 1950's and were classified as major or minor depending, not on their potency, but on their use. The major tranquilizers such as Stelazine, Thorazine, Resperpine, are used with psychotic patients both in hospital and in out-patient programs. They tend to suppress bodily reactions to emotional states, such as aggressiveness and anxiety, and make the patient more amenable to therapy. While the major tranquilizers can be abused, especially when they are utilized to suppress symptoms which remain untreated, they are not readily available to the average woman suffering from "normal" anxiety and therefore are not likely to be the drug of choice of the dependent person.

Minor tranquilizers, which include, Librium, Placidyl, Valium, Miltown, Dalmane, Equanil and Quaalude, are prescribed for less serious emotional disorders marked by anxiety, tension, and irrational fears. They are also used as muscle relaxants. In some people they produce a sense of well-being

and euphoria. These, much more than the major tranquilizers lend themselves to abuse and are conducive to dependence. Frequent and heavy use can produce symptoms such as dizziness, low blood pressure and drowsiness, which symptoms may be interpreted as caused by emotional states and as warranting further dosages of the culprit drug. A number of minor tranquilizers have been shown to be capable of producing physical dependence and of serious withdrawal symptoms if taken over an extended period of time and in high dosages. Abrupt cessation of one of these drugs can result in severe depression, disorientation, agitation, illusions, hallucinations, and even convulsions.[4]

Sedatives

Sedatives are barbituates which depress the central nervous system. They are of two kinds: slow starting, long acting types such as phenobarbital, Amytal and butabarbital; and short-acting, fast-starting group, Seconal, Nembutal, secobarbital. This second type, because of its fast-acting effect is more likely to be abused. The barbituates have been used to relieve anxiety but they are prescribed mainly as sleeping pills. Though they have been known and used for

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[4]Helen I. Green and Michael H. Levy, Drug Misuse . . . Human Abuse (New York: Marcel, Dekker, 1976), pp. 449-450.

over a hundred years, it was not until 1950 that they were shown to cause physical dependence. Misuse of sedatives produces symptoms similar to that of alcohol intoxication, marked by a staggering gate, slurred speech, impaired judgment, and emotional volatility. Abrupt withdrawal can be very serious in its effects, resulting in convulsions, temporary psychosis, and even death. Convulsions may even occur during a period of decreased dosage.[5]

Stimulants

Stimulant drugs such as Benzedrine, Hexedrine, and Methedrine have been in use in medical practice for about thirty-five years. Their main use has been to control narcolepsy, to relieve fatigue in persons with psychomotor impairment, to treat mild depression, to control appetite, to counteract depressant drugs (barbituates and alcohol), and to enhance the action of analgesic drugs. Cocaine used to be used as a local anesthetic of the eyes, throat or mouth, but it has now been replaced by novocaine. Since 1970 FDA regulations have restricted the prescription of amphetamines except for narcolepsy, hyperkensis (mostly in children) and weight reduction. Their use as appetite suppressants is highly controversial, especially since "diet

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[5]Ibid., pp. 331-332.

doctors" can legally give diet pills directly to patients in their own offices without writing prescriptions. Amphetamines, unlike barbituates, bring people up, sometimes to the point of extreme nervousness. They have a strong potential for psychological dependence. In higher doses they may cause confusion, violent or bizarre behavior or hallucinations. Abrupt cessation of use may be followed by severe depression and the risk of suicide.[6]

Narcotics

Many prescribed pain-relievers, such as Darvon, Demerol, and Percodan as well as medicines containing codine are narcotics. They act on the central nervous system with analgesic effects and are therapeutically the most effective pain relievers. Other effects are drowsiness or sedation, respiratory depression, and mood changes. If misused such opiate-type drugs have serious effects including tolerance, (increased doses are needed to obtain the same effect) physical dependency, (the cells of the body are altered by use of the drug so that the drug almost becomes a cell nutrient without which it cannot function normally) and psychological dependence which can produce withdrawal symptoms even before physical dependence has occurred.

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[6]Brenton, p. 12.

If dependence has developed, and the supply of the narcotic drug is cut off, withdrawal symptoms occur. These vary with the degree of physical dependence which has been established. Symptoms begin to appear approximately eight to ten hours after the last dose has been taken. They may include restlessness, insomnia, shivering, irritability, muscular tremors, vomiting, diarrhea. Symptoms may persist for several weeks and are not clearly predictable but seem to vary according to sex, expectation and mythology surrounding the drug.[7]

Physiological Hazards for Women

No doubt, many of the drugs mentioned above have legitimate uses in the treatment of physical and psychic ills. However the facility with which emphasis has been placed on their benefits and their hazards have been minimized or discounted has contributed to problems the magnitude of which we are only beginning to suspect. Even when we are dealing with the use (as opposed to the obvious abuse) of these drugs, the benefit/risk factor has not been weighed with either sufficient seriousness or sufficient knowledge. In particular the benefit/risk factor needs to be weighed with great caution when the patient is a pregnant

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[7]Green and Levy, p. 280.

woman. Myron Brenton in Women and Abuse of Prescription Drugs warns: "The American Academy of Pediatrics has advised its members that no drug has been proven safe for the unborn child."[8]

Drugs ingested by pregnant women pass through the placenta and penetrate the fetal organs, including the brain, before returning to the mother's circulatory system. (Disastrous results of the unwary use of drugs during pregnancy was tragically demonstrated in the case of the "thalidomide" babies of the late 1950's). Diethylstilbestrol (DES), a synthetic hormone, prescribed during pregnancy has been found to increase the risk of vaginal and cervical cancer in female off-spring and to cause an increased risk of birth defects. Similar risks attend when women who use the Pill conceive soon after cessation of the use of this contraceptive. The use of minor tranquilizers such as Valium early in pregnancy increases the risk of clef palate in the baby. One study has suggested a link between the use of minor tranquilizers and such birth defects as heart diseases, mental retardation and partial deafness. Other studies have shown that when women take low to medium dosages of Valium during later stages of pregnancy, significant levels of the drug remain in the baby from eight to ten days after birth, resulting in possible respiratory difficulties and sucking

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[8]Brenton, p. 14.

problems. Barbituates, sometimes given to pregnant women for hypertension, can cause withdrawal symptoms in the newborn child.[9]

Causes of Dependency

It is a truism among drug dependency counselors and in treatment centers that once a person has become dependent, the cause of the dependency is irrelevant in the early stages of recovery. However, knowing something of the cause can be helpful in preventative programs and in formulating a comprehensive recovery program. In this section I will discuss theories which allocate the cause to the chemicals themselves as well as those which consider psychological and sociological causative factors.

While it is apparent that certain toxic properties in the prescribed drugs themselves make their use always, though in varying degrees, hazardous to the health of the user, the degree to which the drugs themselves are the cause of dependency is debatable. Howard Clinebell says that according to a school of thought represented by Robert Fleming the basic cause of alcoholism is alcohol.

> A person begins to drink in compliance with social pressures. One drink leads to two, two to three, etc. Each occasion leads to another of increasing

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[9]Ibid., p. 15.

> intensity as one comes under the sway of the "habit forming properties" of alcohol. The reason why 94 percent of drinkers have not become alcoholics is that they haven't been at it long enough.10

Clinebell disagrees with this explanation. He maintains that the long term use coupled with the need to increase intake in order to maintain a normal, level of functioning is descriptive rather than explanatory of the etiology of alcoholism.[11]

Nils Bejerot, a Research Fellow in drug dependence at the Karolinska Institute, Stockholm, Sweden, has a theory similar to that of Robert Fleming. Bejerot denies that a person has to have a personality problem, a social problem, or a chemical or biological deficiency to become an addict. He holds that any person can become addicted if enough of the substance is induced into the body. Briefly, his theory of addiction is that there are two stages involved. The first, is the period when the person is using or abusing the drug but is in control. This period may be triggered off by almost anything, curiosity, the desire to belong to an in-group, careless medical treatment. The triggering incident has nothing to do with the course of the addiction once it

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[10]Howard J. Clinebell, Jr., Understanding and Counseling the Alcoholic (Nashville: Abingdon Press, 1968), p. 43.

[11]Ibid.

is established. Once established, the addiction enters the second stage in which it takes on the nature of a drive. This artificial drive which is created by ingestion of the drug amounts to a shortcircuiting of the pain-pleasure principle.[12] In popular language, the addict gets hooked on the quick reduction of pain and/or the experience of pleasure. This drive, according to Bejerot is so strong that it is "as difficult for an addict to break his (sic) addiction as for ordinary people to suppress their sexual drives."[13] This theory is, (as Clinebell says of Fleming's), descriptive rather than explanatory. However, it has the merit of delineating two stages in the process, both of which the experience of persons who have become dependent on drugs verify. Contrary to Bejerot who contends that the triggering incident is of no significance, I contend that the cause of the initial use or abuse of the drug is significant, not as an explanation of the addiction phase (which has its own autonomous life) but as clues to particular historical-socio-cultural conditions, and to certain personal characteristics which are restrictive of human growth, whether or not they lead to drug dependency.

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[12]Nils Bejerot, Addiction, an Artificially Induced Drive (Springfield, IL: Thomas, 1972), p. xiii.

[13]Ibid., p. 5.

To illustrate my point I will take for example the case which Bejerot cites. Bejerot tells of a doctor who "was a little worried over periodic impotence," who began to use Ritalin to see if its rumored effect on sexual potency was well founded, and who became addicted to the drug. Bejerot contends that the doctor's impotence was not the cause of his addiction.[14] I would agree. However, I would contend that attitudes towards impotence in the culture, as well as the doctor's perception of impotence are related to his desire to experiment with the drug. An interest in a drug which would possibly cure impotence rather than cancer or baldness does say something about the belief system of the doctor and of the culture. The fact that the doctor considers impotence sufficiently important to favor the benefits of a rumored cure over the risk factor is making a statement about attitudes towards drugs of the doctor in a particular culture. That statement might well be significant. This point will be taken up later in this chapter when I will discuss drug dependency as symptom.

Psychological Factors in Drug-Dependency

Is there a drug dependent type of personality--a particular gestalt of personality traits which distinguishes

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[14] Ibid.

the person who will become drug-dependent from one who will not. Howard Clinebell thinks that there is not. He cites a survey done by E.H. Sutherland et. al. of thirty-seven reports on studies of the personality characteristics of chronic alcoholics. Sutherland and associates found that there is not satisfactory evidence that "emotionally disturbed persons of any type are more likely to become alcoholics than those of another type."[15] Clinebell does cite a list of psychological attributes which have been found and reported in studies of alcoholics. These include: (1) a high level of anxiety in interpersonal relationships, (2) emotional immaturity, (3) ambivalence towards authority, (4) low frustration tolerance, (5) grandiosity, (6) low self-esteem, (7) feelings of isolation, (8) perfectionism, (9) guilt, (10) compulsiveness.[16] However, he goes on to point out that these same traits can be found in neurotics who never become alcoholic.

Regarding a female personality type there is no evidence of a distinct pattern of characteristics in female alcoholics. Cristen Eddy and John L. Ford cite characteristics which have been uncovered in studies of alcoholic females.

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[15]Clinebell, p. 59, citing E.H. Sutherland, et al., "Personality Traits and the Alcoholic, a Critique of Existing Studies" Quarterly Journal of Studies on Alcohol 11:4 (December 1950).

[16]Ibid., p. 53.

These are low self-esteem (the most common trait) depression, and anxiety. There is some evidence that female alcoholics are more likely to suffer from affective disorders than male alcoholics, while sociopathic and psychopathic deviancy are more often reported in men. Again these characteristics also exist in many women labeled neurotic but not alcoholic or otherwise chemically dependent.[17]

It has been customary to characterize alcoholic women as "sicker than male alcoholics." That is, they are said to have greater personality disorders than their male counterparts.[18] However, Lisanski, commenting on this finding regarding women notes that because of the stigma attached to alcoholic women, female sufferers from this disease are likely to be admitted to a clinic at a point when the disease is far advanced and that the personality disturbances noted may well be the result of the ravages of the disease rather than indicative of the condition of her pre-alcoholic personality.[19] It is not apparent that the same explanation applies to women whose drug of choice is a prescribed

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[17]Cristen C. Eddy and John L. Ford, Alcoholism in Women (Dubuque: Kendall/Hunt, 1980), pp. xii-xiii.

[18]Clinebell, p. 38.

[19]Edith S. Lisansky, "Alcoholism in Women: Social and Psychological Concomitants," Quarterly Journal of Studies on Alcohol 18:4 (December 1957), 588-623, cited in Clinebell, p. 38.

medication. Being dependent on a prescription drug does not seem to carry the same stigma as does alcoholism.

However, drug dependent women have been found to have lower self-esteem and higher levels of depression and anxiety than women who are not drug dependent and higher also than men who are similarly dependent. Whether these psychological characteristics precede or are consequent to the dependency is not clear. However, it is noted that the scores of these women do not differ significantly from those of women who evidence other forms of deviant behavior.[20]

Just as there is no clear evidence that female addicts have a pattern of personality traits which distinguish them from non-addicts, so too there is no age or socio-economic level which is immune from the possibility of legal drug dependency. The National Institute on Drug Abuse estimates that there are in the United States somewhere between one and two million women who abuse medication and who subsequently become dependent on these drugs. While a small number of these women procure their drug supplies from the street, most of them do not resemble and do not identify with "street junkies." They are housewives, working mothers, college students, single parents, professionals. They cut

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[20]Beth Glover Reed, "Intervention Strategies for Drug Dependent Women: An Introduction," in George W. Beschner, et al. (eds.) Treatment Services for Drug Dependent Women (Rockville, MD: National Institute on Drug Abuse, 1981), I, 9.

across socio-economic lines to include both the affluent and those on welfare, ranging from a first lady to a destitute single parent. In age they also range widely from teenagers to the elderly. Indeed, Dr. Constance Friess, an internist who specializes in the treatment of the elderly says that "the elderly are particularly vulnerable to the abuse of drugs."[21]

Though there is no addictive profile, there is, however, a certain truth to the addage that dependency comes in persons and not in pills,[22] that is to say, it is related to the person's desire for the drug to fulfill certain needs beyond that for which they initially took the drug. A NIDA study of legal drugs taken by older Americans shows that of the 66 percent of the participants who reported taking prescription drugs, nearly 40 percent said they needed the drugs to perform their daily activities. Many of these were dependent on mood-changing drugs like tranquilizers.[23] Myron Brenton says:

> Old and young, most "pill poppers" as they are sometimes called begin the same way: with a legitimate prescription for mood changing drugs designed to calm them down, allow them to sleep, quiet their physical pain, or suppress their appetites. But when they take the drugs to feel

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[21]Brenton, pp. 1-2.

[22]Adaptation of a quotation, "Alcoholism comes in people not in bottles" in Clinebell, p. 30.

[23]Brenton, p. 2.

> good inside,--or just to get through the day--
> they've gone beyond the purpose for which the doctor
> originally prescribed the drug."24

Sociocultural Factors in Chemical Dependency

Howard Clinebell states that sociocultural factors seem to be of prime importance in the choice of alcoholism as a symptom. He cites availability as a motive for choice and states that if alcohol were not readily available the person with underlying pathology would utilize some other "neurotic" solution for her/his problem. If, however, a person who in spite of inner conflicts can manage to function interpersonally without alcohol is placed in an environment where alcohol is readily available and where drinking is encouraged, he/she is likely to become addicted.[25]

More and more, legal medical drugs are becoming the drug of choice for persons seeking a solution for life-problems. Again as in the case of alcoholism sociocultural factors are highly influential. Robert Hughes and Robert Brewin attribute to a variety of cultural attitudes the contemporary reliance on the pill solution to everything from headache to existential anxiety. They say that the abuse of tranquilizers is partly the result of the deification

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[24]Ibid.

[25]Clinebell, p. 60.

of science (it can do no wrong), partly the result of the search for life without pain, partly the result of advertising tactics on the part of drug manufacturers, and partly the ease with which a prescription or over-the-counter drug can be obtained.[26]

Sociocultural Factors in Women's Dependency

Psychological profiles of female addicts are most seriously challenged by feminist thinkers. Beth Grover Reed in an article mentioned earlier states that women who abuse drugs share many characteristics with one another and with women who are not drug dependent. She says "Many problems and issues that treatment of drug dependent women must address are related more to their being women than to their chemical dependency."[27] Commenting on the consistent findings that women express lower levels of self-esteem and higher levels of depression and anxiety across all social classes, Reed cites the fact that there is considerable evidence that women's and men's roles are not valued equally by society and that a large proportion of so-called masculine characteristics are considered more "healthy" by a number of

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[26]Richard Hughes and Robert Brewin, The Tranquilizing of America (New York: Harcourt, Brace, Jovanovich, 1979), p. 12.

[27]Reed, p. 7.

clinicians. She goes on to say that persons with lower status internalize society's belief about them and hence feel less good about themselves and tend to orient themselves towards those who have more power. "Thus they devalue themselves and others like themselves. They have lower expectations of their lives, and tend to be more concerned about surviving and minimizing their discomfort than about getting ahead."[28]

Reed goes on to say that "learned helplessness" resulting from physical and emotional abuse accompanied by feelings of powerlessness is also characteristic of drug-dependent women. Seligman has found that animals who are negatively reinforced no matter what they do to try to escape a painful stimulus or to control a situation, stop trying in a relatively short time and rather than struggle to escape they will even succumb and die.[29] It is not surprising that a woman who sees no alternatives other than endure her current situation may use drugs to minimize the distress, to survive or in some cases to commit slow suicide.

In the stories recounted in Chapter 2, Bea, Joan and Ellen in particular exemplify attitudes and behavior consistent

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[28]Ibid., pp. 8-9.

[29]M.E. Seligman, "Depression and Learned Helplessness," in R.J. Friedman, and M.M. Katz (eds.) The Psychology of Depression (Washington: Winston, 1974), cited in ibid., p. 9.

with learned helplessness. Bea endured marriage to an alcoholic first husband without taking steps to change anything in her life. The apparent psychoanalytic approach of the counselor she saw at that time would have confirmed her sense of helplessness by focusing on what was wrong with her rather than encouraging her to consider what choices she had in her situation. Later in her second marriage her stepson was allowed to control the household. Again, Bea did not insist that anything be changed. Joan moved thirty times without exercising any control over her life. Wherever her husband went she went too. It never occurred to her that she had any option, so engrained in her was the good wife sex-role stereotype. Ellen chose suicide as an escape from her abusive husband. Simply leaving him did not seem a preferable option. Role-expectations kept all of these women trapped in self-destroying situations.

In general, societal expectations place more limitations on women than on men especially in the areas of sex and anger. In particular, expressions of anger or aggression are considered "unfeminine." Many women have considerable conflict and guilt about feeling angry and have developed few skills related to self-assertion. Homemaker and family-related roles cause many women, including the drug-dependent, to feel that they have no option other than to continue and endure their responsibilities. Reed cites Howard and Clevin in support of the assertion that enduring is a common coping pattern for women. She also notes that these authors suggest

that it is difficult for a woman to see any other options if she believes that her situation is biologically determined.[30] The woman who has internalized her role well has also internalized with it a strong sense of helplessness.

Homemaking and family roles prevent women from having much contact with other women; this isolation is greatly aggravated for drug-dependent women. Such isolation prevents them from making a connection between the situation they are experiencing and broader social patterns. Hence such women tend to blame themselves for situations they cannot change or control because they do not know that many of the problems which they face are shared by all women.[31] It is significant that it was not until Bea heard other women share in her therapy group in hospital, that she learned that other families have problems too.

Family of Origin and Drug Dependency

Cuskey and Wathey in "A model of Female Addiction" note the following characteristics in the families of origin of female addicts:

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[30] R. Cloward and F.F. Piven, "Hidden Protest: the Channeling of Female Innovation and Resistance," Signs 4:4 (1979) 651-69, cited in ibid., p. 10.

[31] K. Deaux and T. Einswiller, "Explanations of Successful Performance on Sex-linked Tasks: What is Skill for the Male is Luck for the Female," Journal of Personality and Social Psychology 29 (1974), 80-85, cited in ibid.

1. Poverty which led to family disruption, discord and inadequate child-rearing practices;

2. Family disorganization caused by death, separation or divorce;

3. Parental alcoholism and to a lesser extent drug abuse, high instance of mental disturbance and to a lesser extent criminality;

4. Rejecting home environment--mothers either overindulgent or cold and authoritarian, father indulgent and seductive;

5. Inappropriate familial socialization resulting in inadequate sexual identity (studies reviewed indicated that one fourth of female addicts had experienced incestuous sexual relationships).[32]

Josette Mandanaro found three interacting elements involved in the etiology of female addiction: (1) strict sex-role socialization, (2) emotional neglect as an infant, (3) untimely and unrealistic performance expectation by parents. Mondanaro sees criticism for failure to meet high parental demands as a basis for the personal sense of inadequacy which she found in female addicts.[33] Cuskey and Wathey report that Binion found 82 percent of the addicts in

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[32]Walter R. Cuskey and Richard B. Wathey, "A Model of Female Addiction," in their Female Addiction (Lexington, MA: Health, 1982), pp. 135-137.

[33]Ibid., p. 137.

her sample had been as children subjected to severe physical punishment, often for no reason.[34]

Women and the Medical Profession

Another factor of significance in the use and abuse of psychotropic drugs is the attitude of physicians towards women. As Ruth Cooperstock--a research scientist in the Addiction Research Foundation of Ontario, Canada, says "Prior to any discussion of psychotropic drugs, it is necessary to recognize that these are the products of a particular relationship--(that of) the patient to his or her doctor."[35] Ms. Cooperstock points out that in the nineteenth century the American middle and upperclass woman was considered "sickley" while working class women were seen as sturdy and innately healthy. This mythology served the economic interest of the medical profession. Today there is a mythology which connects women with neurosis and neurosis with stress and this view is possibly a basis for the high rate of psychotropic drug prescribing and use among women.[36] Needless to say current

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[34]V. Binion, "Women's Drug Research Project," in Contemporary Drug Problems, Fall 1977 cited in ibid., p. 137.

[35]Ruth Cooperstock, "Women and Psychotropic Drugs," in Anne MacLennan (ed.) Women, their Use of Alcohol and Other Legal Drugs (Toronto: Addiction Research Foundation of Ontario, 1976), p. 83.

[36]Ibid.

mythology regarding women's illnesses serves the economic interests of drug companies. Myron Brenton quotes data which indicates the extent to which women are the major recipients of drug prescriptions. He states that of the 121 million prescriptions that doctors write for psychotropic drugs twice as many go to women as to men. Seventy percent of antidepressant drugs and eighty percent of stimulants go to women. A 1977 NIDA survey indicates that of persons over 65 nearly three times as many women as men reported using tranquilizers, sedatives, and antidepressants. In 1980 six out of ten persons admitted to emergency rooms because of Valium overdose were women. Why this preponderance of women receiving drug prescriptions? One reason is that women see doctors more frequently than men: almost sixty percent of all visits to physicians are made by women. However this does not fully account for the phenomenon.[37] Another factor is that "women are less likely than men to deny their problems. They cope by seeking help--from family, friends and clinics. Women are the primary consumers of health care for both themselves and their families. They tend to define their feelings of dis-ease as health problems and take physical and more global problems to their doctors."[38]

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[37]Brenton, pp. 2-3.

[38]Cooperstock, p. 91.

Expansion of Medical Model

While the medical model applied to alcoholism and drug dependency is useful in alleviating guilt and in certain aspects of treatment, there is a distinct hazard in the contemporary tendency to universalize the medical model to include simple life problems. Ruth Cooperstock found (in a study of physician's perceptions of symptoms most frequently seen in their practice) that such problems as sleeplessness, general feelings of unhappiness, headache, and fatigue, as well as loneliness, financial difficulties and problems with children are seen as more common female issues. She states:

> If financial difficulties, loneliness, disobedience of children are commonly seen problems presented to physicians, then we must hardly be surprised by the increase in psychotropic drug consumption that has taken place in the past decade.
>
> These "problems of living" have somehow become medical problems by definition, if only because they have been presented in the physicians office. We have reached the chicken and egg dilemma and can ask the question: Would so many social, personal problems be defined as medical problems today if psychotropic drugs didn't exist? Conversely, would psychotropic drugs have proliferated as they have if the pharmaceutical industry had not helped to "medicalize" living.39

Defining problems of living as medical constitutes a mythology in so far as a meaning consistent with the

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[39]Ibid., p. 87.

patriarchal assumptions of the medical profession (i.e. that women possess inherently deficient psyches) regarding women is the basis for diagnosis and treatment. If the assumption is that women are psychologically incapable of coping with the stresses of life, then it seems logical to prescribe something to help them to cope. This approach leaves untouched environmental and cultural sources of the woman's distress and ignores the fact that the symptoms may be a healthy reaction to an unhealthy situation. Ruth Cooperstock points out that physicians as a group have attitudes influenced by a variety of elements: early experience, continuing education courses, pharmaceutical advertisements, and by their patients. She asserts "Myths and shibboleths regarding females still seem endemic to in most medical education with the result that identifiable an treatable gynecological problems are diagnosed as psychological in origin."[40] Prejudicial attitudes towards women expressed in pharma-

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[40]See the following: K.J. and R.J. Lennane, "Alleged Psychogenic Disorders in Women, a Possible Manifestation of Sexual Prejudice," New England Journal of Medicine no. 6 (August 8, 1973), 288-92.

J. Prather and L.S. Fidell, "Sex Differences in the Content and Style of Medical Advertisements," Social Science and Medicine 9:11 (January 1975), 23-26.

G. Stimson, "Women in a Doctored World," New Society 23:656 (May 1975), 265-67.

C. McRee et al., "Psychiatrists' Responses to Sexual Bias in Pharmaceutical Advertising," American Journal of Psychiatry 131:1 (November 1974), 1273-75.

ceutical advertisements are well documented by Lennane and Lennane, Prather and Fidell, Stimson and McRee, Corder, and Haizlip.

Lennard, Epstein, Bernstein, and Ramson delineate the collusion between the medical profession and the pharmaceutical industry. They state:

> As we defined it . . ., this concept of mystification involves the communication of false and misleading explanations of events and experiences in place of accurate ones, explanations which serve one party at another party's expense.
>
> In the context of current usage, drugs are medical agents whose function is the solution of medical problems; only to the extent that interpersonal and other problems can be construed as medical-psychiatric problems can they be considered appropriate targets for drug treatment. As more and more facets of ordinary human conduct, interactions and conflicts are construed to be medical problems physicians and subsequently patients, become convinced that intervention through the medium of psychoactive drugs is desirable or required.41

These authors cite several advertisements offering Valium, Librium, Vistaril and Tofranil as treatment for conflict experienced when a young woman first goes to college, childhood anxieties such as school and dental visits, parental anxiety over a run-away teenager. The advertisements suggest that normal reactions to these

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[41]Henry Lennard et al., Mystification and Drug Abuse (San Francisco: Jossey-Bass, 1971), p. 18.

situations is pathological and requires medical treatment. The authors conclude:

> When a physician prescribes a drug for the control or solution or both of a personal problem of living, he (sic) does more than merely relieve the discomfort caused by the problem. He simultaneously communicates a model for an acceptable and useful way of dealing with personal and interpersonal problems. . . .42

Not only does the pharmaceutical industry collude in the medical patriarchal mythology, it also woos the medical practitioner with economic, scientific, educational and professional bait. Lennard et al. describe the relationship between the drug industry and the medical profession as symbiotic. They state that the industry depends on doctors to sell their products through the authority of their medical status and through their exclusive use of prescription, and to introduce new drugs and monitor their use. On the other hand it provides for doctors a flow of information about its products, gives free samples, produces journals which intersperse medical information with drug propaganda, and finances medical education. The extent of this conflict of interests is succinctly expressed as follows:

> Scientific reports on specific drugs (psychoactive drugs among them) are often written by staff writers employed by the industry and are based upon information supplied to them by physicians remunerated by

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[42] Ibid., pp. 21-23.

> the pharmaceutical firm to assess the drug which it hopes to market.43

In Gyn/Ecology Mary Daly sees the intent of the medical profession as (consciously or unconsciously) the subjugation of women. It is not necessary to identify fully with her thesis to suspect that the tranquilizing of women is at least to some extent motivated by the need to maintain oppressive structures but also to avoid being confronted by their life-destroying consequences.[44]

It is safe to say, then, that the causes of dependency on prescribed drugs has many facets. One might say that the facet with the widest context is the cultural stereotypical view of women as inferior--a view which is deeply embedded in the history of the race and which, though changing somewhat, is still the prevalent one. Within that context are the majority of women who, because they have internalized the cultural view suffer from low self-esteem and experience stress not only from their personal limitations but also from the limitations which are placed on them by an oppressive society. Within that wide context we have the medical profession with its patriarchal history of oppression and exploitation of women and with attitudes towards and myths

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[43]Ibid., pp. 38-39.

[44]Mary Daly, Gyn/Ecology (Boston: Beacon Press, 1978).

about women which individual doctors have in varying degrees internalized. Within the context too we also have the pharmaceutical industry, dedicated to profit and willing to capitalize on the destructive myths and oppressive power regime of the medical profession. Add to this a religious environment which canonizes stereotypical "feminine virtues" and we have a world in which any woman might be a candidate for some form of dependency. Those women who have been particularly deprived of nurturing in childhood and/or who have been physically, sexually or emotionally abused are particularly high on the candidacy list. If such women should in a time of crisis consult a doctor who from the heights of medical patriarchal power offers the instant chemical salvation, the possibility that she will become dependent are high indeed. The dependency which such a woman experiences is not only dependency on a self-destroying drug but dependency on a self-betraying system.

Spiritual Implications of Dependency on Prescribed Drugs

The spiritual implications of dependency on prescribed drugs have a bearing on both the individual and the culture. For both, the entire drug ethos amounts to a religion which promises instant transcendence.

The "miracle" aspect of drugs (somewhat less touted in recent years) is, in the first place, compellingly

attractive because we are easily seduced by the lure of cheap grace. Take a pill and you are transformed from an angry, hurt, resentful, peevish, complaining, lonely, tired, discouraged or fearful human being into a sweet, accommodating, forgiving, courageous angel of light. The initial boost to one's self-esteem is tremendous.

However, there are two problems with this form of salvation. The "transformation" doesn't last. It requires constant shots of "instant grace" which become increasingly less effective, until the last state of the "sinner" is much worse than the first. For the individual there is no real transcendent growth, only regression. Instead of the joyful openness towards the world of nature and people which makes for growth in transcendence there is withdrawal from that world. The woman who becomes dependent on drugs returns to a mode of passive endurance of life, more profound than that of her premedicated state.

Secondly, the conditions which originally evoked anger, fear, resentment, and the gamut of feelings which have to be tranquilized remain unchanged. There is no miracle drug for them. The drug ethos ignores the interpersonal/ cultural nature of the problems which beset the woman in the first place. The problems being ignored are fundamentally spiritual. Not only is the individual oriented towards the transcendent (as Rahner and Schillebeeckx say) but the culture and the cosmos are similarly directed. Anesthetizing the

victims of our life-denying attitudes and behavior renders us blind to the signs of our collective sinfulness and deaf to the call to transcendence.

The medical drug ethos arises from the medical profession's need and our need for omnipotence. We confuse transcending with overcoming. We seek to master problems instead of opening ourselves to inner transformation. I do not mean to imply that there is no place for the solution of problems in a world oriented towards transcendence, but problem-solving should be an aid towards living the mystery of life rather than a substitute for it. Grace, which is the power to live the mystery of being does not come in a pill or a capsule.

In the following chapter I will explore how a deficient theology of suffering, sin, and hope have misdirected women's search for a transcendent life and how a renewed theology of these aspects of human experience could widen her choice of paths and support her in her spiritual quest.

Course of Dependency

The following chart indicates intervention points and appropriate intervention during the process of drug-dependency:

Progressive Stages	Intervention
Stage I	
Normal Use: For short term medical crisis or emotional trauma	Ascertaining that the woman understands the hazards as well as the benefits of the drug, recommending alternative or additional ways of dealing with the problem for which the drug has been prescribed
Stage II	
Dependency Stage:	
A. Needing drug periodically for serious but not traumatic life crises	Caring confrontation on her drug-abuse
B. Needing drug for minor crises	Referral to doctor/counselor acquainted with a drug-dependency
C. Needing drug to get through the day	Referral of spouse and family to Alanon and/or other self-help group for relatives of the chemically dependent
D. Running away--may leave family without warning	
Stage III	
Despair Stage:	
A. Profound withdrawal from social contact	Procuring Crisis Counseling for spouse and family
B. Sleeping a lot--insomnia--anorexia	Helping family to have woman admitted to a drug-treatment facility
C. Suicide attempts, child neglect or abuse	On-going contact and support of woman and family during treatment

Stage IV

Recovery Stage:

A. Detoxification

B. Physical, psychological and spiritual rehabilitation

Chapter 4

THEOLOGICAL DIMENSIONS OF SUFFERING
HOPE AND SIN

> Mrs. Pontillier was beginning to realize her position in the universe as a human being and to recognize her relations as an individual to the world within and about her. This may seem like a ponderous weight of wisdom to descend on the soul of a young woman of twenty-eight. Perhaps more wisdom than the Holy Ghost is usually pleased to vouchsafe to any woman.1

The Risk and the Cost of Awareness

This is how Kate Chopin describes the heroine of her novelette, The Awakening. Edna Pontillier is a woman who has glimpsed in childhood, through a natural mystical experience the open possibilities of her being. She recalls memories ". . . of a summer day in Kentucky, of a meadow that seemed as big as the ocean to the very little girl walking through grass which was higher than her waist. She threw out her arms as if swimming when she walked, beating the tall grass as one strikes out in the water." Commenting on the novelette, Carol Christ calls this awakening a spiritual conversion. "It concerns Edna's recognition of the nature and potential of her soul" Edna begins to become

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[1]Kate Chopin, The Awakening and Other Stories (New York: Holt, Rinehart and Winston, 1970), p. 214.

aware of the qualities of her own marriage.[2] After her husband had awakened her to care for the children who were asleep and did not need her attention, she went out on the porch to cry. "An indescribable oppression, which seemed to generate in some unfamiliar part of her consciousness filled her whole being with a vague anguish.[3] Chopin tells us that "Even as a child (Edna) had lived her own small life all within herself. At a very early period she had apprehended instinctively the dual life--that outward existence which conforms, the inward life which questions.[4]

It seems to me that Kate Chopin captures precisely and poignantly Edna's inner awareness of what Karl Rahner calls openness to the transcendent. It first comes to Edna the child in a Kentucky meadow "seeing the stretch of green before (her) and feeling as if she must walk on forever."[5] It emerges again in Edna the woman swimming with her face turned seaward "to gather in an impression of space and solitude which the vast expanse of water, meeting and melting with the moonlit sky conveyed to her excited fancy," seeming as she swam "to be reaching out for the unlimited in which

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[2]Carol P. Christ, Diving Deep and Surfacing (Boston: Beacon Press, 1980), p. 29.

[3]Chopin, p. 202.

[4]Ibid., p. 215.

[5]Ibid., p. 218.

to lose herself."[6] But Chopin ends her story with Edna's suicide, when after Robert (a young admirer) has declared his love for her and has left a note saying, "Goodbye because I love you," she swims for the last time until "the shore (is) far behind and her strength (is) gone."[7] Carol Christ interprets Edna's mystical experiences, not as a transport out of the body into a transcendent world, but as an experience of wholeness in which she discovers the power of her body and soul. "For her, physical, sexual, social and spiritual awakening occur together." This awakening starts her social quest, "a search for new ways of living in human community."[8] Failing to find a new way, or lacking the courage to go on struggling against the odds, Edna chose suicide in the form of a mystical reunion with the ocean.

The strength I see in the theological formulations of Rahner and Schillebeeckx is that they validate the inner spiritual experience and the need for a social quest to incarnate that experience. However, few women of this generation will find it possible to give concrete form to that quest without the support of more salugenic religious and secular structures. As her more liberated friend, Mademoiselle Reisze tells Edna, "The bird that would soar

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[6]Ibid., p. 232.

[7]Ibid., p. 341.

[8]Christ, p. 31.

above the level plains of tradition and prejudice must have strong wings. It is a sad spectacle to see the weaklings bruised, exhausted, fluttering back to earth."[9] The fear of becoming that sad spectacle is sufficiently realistic to keep many women in the security of the status quo, and enough to entice others who have attempted to soar a little to return to the plains of tradition and prejudice.

Theory-Practice Gap: A Double Message

There are several key areas in which Catholic speculative theology (even that which is theoretically liberating) contributes to the stultification of women. First is the gap between theory and practice. Traditional theologies which explicitly condemned and oppressed women had one merit: they were consistent. New developments in Catholic theology have generated more liberating statements, enough to give rise to very fragile and rapidly dashed hopes. The Vatican II document on the Church proclaimed a common dignity of members in the Church stating, "In Christ and in the Church there is . . . no inequality arising from race or nationality, social condition or sex. . . ."[10] The document

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[9]Chopin, p. 301.

[10]Austin Flannery (ed.) Vatican Council II (Northport, NY: Costello, 1975), p. 391.

led the way to the opening of certain ministeries to laity, but it soon became apparent that lay men literally meant lay men and if women were to be admitted to function, for example, as Eucharistic ministers it would only be in the absence of qualified males. Removing the theological barriers to lay Eucharistic ministry only served in many instances to aggravate the sense of inequality. The sign which previously read "No laity need apply," now reads "No women need apply," or "Women only in extreme necessity." Oppression and discrimination is not erased, it merely takes on the dimension of ambivalence.

Pastors are exorted to involve the laity in decision making--indeed the way seems open to such inclusion at all levels of decision making.

> By reason of the knowledge, competence or pre-eminence which they have, the laity are empowered indeed sometimes obliged to manifest their opinion on those things which pertain to the goal of the church. . . .11

Yet, in practice, the opinion of the laity is not often consulted, and when it is, it is frequently discounted. In particular, the knowledge, competence and pre-eminence of women is not noticeably welcomed or esteemed in the decision-making councils of the church at any level.

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[11]Ibid., p. 394.

Likewise, the document on Religious Liberty declares that the human person has the right to religious freedom which includes freedom of conscience.

> It is through his conscience that man (sic) sees and recognizes the demands of the divine law. He is bound to follow this conscience faithfully in all his activities so that he may come to God who is his last end. Therefore he must not be forced to act contrary to his conscience. Nor must he be prevented from acting according to his conscience especially in religious matters. The reason is that the practice of religion of its very nature consists primarily of those voluntary and free internal acts.12

The declaration on religious freedom is spoken to a people formed to obedience to external authority. In the case of women this authority carries a double impact, for women were not only schooled in obedience to civil and ecclesiastical authority, but also to the males in their lives--to be obedient was an essential feminine virtue. Now the focus of obedience has been shifted, at least in part, to the internal realm, but the fear and guilt is not thereby removed. Instead, for some, another "should" has been added. I should be capable of being autonomous without fear and guilt. A woman's search for autonomy may lead to the divorce court from which she emerges with an extra load of guilt for having betrayed her spouse and children. How can one who has been told that

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[12]Ibid., pp. 801-802.

she is the "heart of the home" choose herself over her home without almost debilitating guilt?

This gap between theory and practice and the attendant ambivalence which it engenders has also its counterpart in the secular social sphere where women are encouraged to develop careers for both personal and financial reasons and are yet expected in many cases to devote themselves simultaneously to full-time child rearing and home making. Moreover, little or no provision is made by employers for the special needs of the working mother. Indeed, the label "working-mother" or career woman still carries a stigma despite some rhetoric to the contrary. Nor does the Church do much to erase that stigma holding as it still does in practice to the image of the ideal home in which the father is "the head" and the mother "the heart."

Valerie Saiving Goldstein states the ambivalent position of women vis-a-vis the Church quite accurately when she says:

> My purpose . . . is to awaken theologians to the fact that the situation of women, however similar it may appear on the surface of our contemporary world to the situation of man and however much it may be echoed in the life of individual men, is, at bottom, quite different--that the specifically feminine dilemma is, in fact, precisely the opposite of the masculine. Today, when for the first time in human history it really seems possible that those endless housewifely tasks--which, along with the bearing and rearing of children, have always been enough to fill the whole of each day for the average woman--may virtually be eliminated; today when at last women might seem to be in a position to begin to be both feminine and fully developed, creative human beings;

> today these same women are being subjected to pressures from many sides to return to the traditional feminine niche and to devote themselves wholly to the task of nurture, support, and service of their families. One might expect them to support and encourage the woman who desires to be both a woman and an individual in her own right, a separate person, some part of whose mind and feelings are inviolable, some part of whose time belongs strictly to herself. . . . Yet, theology, to the extent that it has defined the human condition on the basis of masculine experience, continues to speak of such desires as sin, or temptation to sin. If such a woman believes the theologians, she will try to strangle such impulses in herself.13

Related to the gap between theory and practice in Catholic theological anthropology is the inherent static character which this philosophy inherits from its philosophical origins. Philosophy abstracts from life experience, formulating cognitive explanations, using static nouns such as "being" and "transcendence." The use of nouns gives the impression that what is referred to is an already accomplished state rather than an on-going process. Catholic women need to inject life into the reified language of philosophical theology by using such terms as "becoming" and "transcending." We are at every moment becoming and transcending persons. The very use of active verbs startles, diffuses cliches, claims possibilities and rights.[14]

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[13]Valerie Saiving Goldstein, "The Human Situation: a Feminist Viewpoint," in Simon Doniger (ed.) The Nature of Man (Plainview, NY: Books for Libraries Press, 1973), pp. 166-167.

[14]See Nelle Morton, "The Rising Woman to Consciousness in a Male Language Structure," Andover Newton Quarterly 12 (March 1972), 177-90.

Woman's Growth and Sin

In the section from Valerie Saiving Goldstein's article quoted above, a theological issue of significance for women was highlighted, the masculinization of sin. Personal conscience is not formed in a vacuum; it is to a great extent the personal appropriation of communal values and norms. Moral and ethical decisions, whether they coincide with or run counter to communal beliefs and norms are not made without reference to them. Charles Gallagher states this fact from a Catholic perspective when he says:

> We have to recognize that we are acting as the Church in everything we do. We're deciding for the Church in the very decisions that we make for our own lives. Therefore, the Church--that is, the people--have got to be involved in those decisions because they affect the quality of their lives as Church.
>
> Basically what we're saying is that we as Catholics should have a communal conscience. It's just like being a family member. When you're really part of a family, the whole family should be involved in the basic decisions you make. The same thing is true of being Catholic. We don't just live by ourselves. We're immersed in the body of Jesus and every other member of that body is influenced very definitely by the decisions each of us makes.15

Karl Rahner speaks of sin as fundamentally that radical "No" to life in the context of the transcendent. A

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[15]Charles Gallagher, S.J., Being The Body of Christ, The Parish Renewal Weekend Pamphlet, (Elizabeth, NJ: 1978), p. 35.

"Yes" or a "No" to life is, in the last analysis, the responsibility of the individual; however, the vision of what constitutes that fulness of life, as well as its relationship to concrete options, is formed within the community whose traditions are both a gift and a burden. The vision of life's fulness formed within the Catholic community, like that of other traditions has been biased towards masculine values and this bias takes the form of two interwoven patterns.

Universal Application of Male Sin Model

First, sin has been seen as the distortion of tendencies which have been nurtured culturally in the male; in delineating sin, theologians have considered literally the condition of man before God and have come up with a catalogue of valid but one-sided transgressions. As Valerie Goldstein says:

> It is clear that many of the characteristic emphases of contemporary theology--its definition of the human situation in terms of anxiety, estrangement, and the conflict between necessity and freedom; its identification of sin with pride, will-to-power, exploitation, self-assertiveness and the treatment of others as objects rather than persons, its conception of redemption as restoring to man (sic) what he fundamentally lacks (namely, sacrificial love, the I-Thou relationship, the primacy of the personal, and ultimately, peace)--it is clear that such an analysis of man's (sic) dilemma was profoundly responsive and relevant to the concrete facts of modern man's existence. . . .

> . . . this theology is not adequate to the universal human situation; its inadequacy is clearer to no one than to certain contemporary women. These women have been enabled through personal experience and education, to transcend the boundaries of the purely feminine identity. . . . They believe in the values of self-differentiation, challenge, and adventure and are not strangers to that "divine discontent" which has always driven me.16

Goldstein goes on to say that the temptations of Woman as woman are not the same as the temptations of man as man. She says that women's sins which are "outgrowths of the basic feminine character-structure" cannot be described in terms of pride and will-to-power. While Goldstein comes in this statement too close to positing a "basic feminine character-structure" than the present state of the question warrants, there is a great deal of validity in her assertion whether one favors the nature or nurture explanation of "feminine character-structure." Women's sinfulness it would seem takes a different form from that of men. It tends to arise, not so much from hubris as from diffidence, from such characteristics as "triviality, distractibility, and diffuseness: lack of an organizing center or focus; dependence on others for one's own self-definition; tolerance at the expense of standards of excellence; inability to respect the boundaries of privacy; sentimentality, gossipy sociability,

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[16]Goldstein, p. 163.

and mistrust of reason--in short, underdevelopment or negation of the self."[17]

While pride and will-to-power (especially power over women) designates appropriately the fundamental male sin, woman's original sin is quite the opposite. It lies rather in her will to subordination, her lack of the courage to become, to name and resist the forces that oppress her. To overcome that fundamental sinfulness of self-denial, woman must own sisterhood and act in solidarity with her oppressed kinswomen. Women is saved not in isolation but in community. Behind the specific surface tendencies that I will subsequently describe lies that basic original sin of will to subordination, of which these are many concrete manifestations in the attitudes and behavior of women.

Sin and Women's Subordinate Role

I do not espouse the "basic feminine character-structure" theory of female personality. However, it would be denying the obvious to assert that there are no differences (over and above the genital) between women and men. I believe, however, that these differences arise mainly from the inferior position of women, a position towards which women have been socialized since infancy. When I speak of

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[17]Ibid., p. 165.

women's sin concretely I am referring to certain tendencies and behaviors in women as a group which constitute obstacles to women's growth towards wholeness and simultaneously impede their transcending. It is not my intention here to impute blame or to judge women subjectively, but merely to say that the condition of women is because of the "original sin" of sexism a sinful condition. We women need to seek and assume the power to overcome that sinful condition as it operates concretely in our lives. Moreover, an aspect of the mission of the Church is to enable women in this struggle.

Jean Baker Miller in Towards a New Psychology of Women delineates certain salient characteristics of subordinate groups which are relevant in an investigation of the condition of women before God. She says that:

1. Because the subordinate group has to concentrate on survival they tend to avoid direct, honest reaction to destructive treatment

2. Because of fear of punishment and reprisal subordinates resort to indirect and disguised ways of acting and reacting

3. Subordinates absorb a large part of the untruths told to them by the dominant group

4. Some members of subordinate groups imitate the dominants.18

I will discuss here ways in which these tendencies result in self and other-destructive attitudes and behavior.

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[18]Jean Baker Miller, Towards a New Psychology of Women (Boston: Beacon Press, 1976), pp. 10-12.

Frequently and tragically we hear of women who remain in a destructive situation such as a home in which they are being abused because they do not have, or think they do not have, the means to survive elsewhere. They will even connive at the abuse of their children on the part of the father or other male within the family without serious protest. Sometimes, they do not see what is apparent to others because they cannot afford to see what would force them to initiate change. Linda who still suffers emotionally from her father's abuse is also deeply hurt by her mother's failure to see what was happening to her and to intervene. Along with this passivity we find also the tendency to excuse the aggressor by blaming the self or the victim. Basically such a woman has bought the story that she deserved punishment. This attitude amounts to tolerance at the expense not merely of standards of excellence (to use Goldstein's term) but of standards of human dignity and justice. In a less dramatic way women will accept verbal and behavioral "put-downs" without protest for fear or offending members of the dominant group.

Related to passivity in the face of abuse is the tendency to respond in indirect or disguised ways. Women more than men feel guilty about feeling or expressing anger. Hence they tend to manifest its presence in disguised ways. They may withdraw and become depressed, become physically ill, quietly sabotage the other's plans and efforts, or even

attempt suicide. This type of behavior as well as being self-punitive also serves to punish the offender who may be unaware that he has offended. Several of the women who became dependent on prescribed drugs tended to put up with unfair, or intolerable conditions. Their self-destructive use of prescribed drugs may possibly have been their indirect reaction to conditions which should have provoked anger and consequent direct action. In the case of Margaret this self punitive reaction is more apparent in her repeated suicide attempts some of which occurred shortly after an incident at home or elsewhere over which she might be expected to have been angry.

Absorbing the distortions and untruths which have been foisted on her by a patriarchal culture, woman has lost contact with her own center--her perception of herself. However, there is always a sense in which she cannot entirely suppress the truth of herself. As a result she often lives out a half-conscious dishonesty. Some of the untruths which she has internalized are that women are passive, women are weak, women are not intellectual, all women love children. Women are not as a group passive; they are quite active in the types of activity which are culturally sanctioned as proper for women. Women are not weak, in fact they have a longer predicted life-span than men; they can lift heavy weights including children. Knowing what is acceptable to males, women may play passive or stupid or fragile in order

to please or to avoid threatening the male. Some women do not like children, but to confess that would be tantamount to claiming to be sub-human. As a result some women give double messages to their children; on the surface they are loving even over-indulgent but the smiling mask hides a resentful face. The tendency to try to live out of myths about herself alienates woman from herself and from others, especially from other women who have divested themselves of the same myths. For this reason some of the strongest opponents of women's liberation are women themselves.

Imitating the dominant group is also a hazard for women. This imitation may take the form of using male tactics to attain female goals; for example, using violence or deceit in pursuit of power even when the power sought is legitimate. To be true to themselves, women must pursue their aims in ways consistent with their own values, the ways of peace, justice and mutual respect. Another way in which women may imitate their oppressors is to treat other women in the same way as sexist males do. This failing is a particular liability for the token women in a male organization or institution who allows herself to be co-opted by the patriarchy as a price for acceptance.

Finally, a paramount failing of women is her refusal to take her own needs seriously enough to do something about them even when she can. This neglect of self leads to the martyr complex. Because such a woman over-invests herself

in taking care of others, she expects others to take care of her and becomes bitter and self-pitying if they do not do so. Elizabeth Friar Williams describes this particular form of "sinfulness" under the name "victim."

> Women are certainly members of . . . an oppressed group. The psychotherapy of women therefore has to deal with the psychological effects of true victimization, such as low-self-esteem and feelings of helplessness. It must also, however, deal with the use of this real victimization by some women as a defense against recognizing whatever is their own responsibility for the place where they are in their lives. Without both a sense of responsibility and a feeling of potency, no "victim" can hope to change her situation.19

It is difficult for women to recognize and confront the attitudes and behaviors in themselves which might be termed sinful because in the patriarchal system sin is defiance of patriarchal authority, rebellion, self-assertion. Women seldom sin in this way. As described above they have their own particular predominant defects, many of which, however, are likely to pass as virtues rather than failings.

There is a second strand in the masculine bias in the definition of sin. This bias is rooted in the mistake of equating inherent sinfulness with selfishness, and salvation with sacrificial love. This model may be true for some people at certain periods in history, but for contemporary women it is fraught with stultifying implications. Because

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[19]Elizabeth Friar Williams, Notes of a Feminist Therapist (New York: Dell, 1976), p. 159.

the so-called feminine virtues of nurturance, surrender, and self-giving are part of the human experience for which women have been "carriers" any reaction on the part of women against that role is very threatening. Even a modicum of will-to-power or self-assertion on the part of a woman is seen in a very exaggerated way and condemned. What may be healthy self-esteem or necessary self-nurturance can be dubbed selfish and sinful. But what may indeed be sinful pride in a male, is often wholesome self-confidence in a woman. Yet, a woman is more severely condemned for the so-called masculine sins. The net result of this masculine bias in the theology of sin is that women are often reenforced in behavior which keeps them from developing their full human potential and condemned for the stirrings of autonomy and adult independence. Jean Baker Miller sums up, in the following statement, the dilemma in which this view of sin places women:

> If the refusal to become selfless is wholly sinful, then it would seem that we are obliged to try to overcome it; and when it is overcome, to whatever extent this may be possible, we are left with a chameleon-like creature who responds to others but has no personal identity of his (sic) own.20

Behind several of the sinful tendencies which Valarie Goldstein mentions earlier lies the basic conviction under which many women suffer, i.e., that the source of all good

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[20]Miller, pp. 169, 170.

resides outside of themselves. From this conviction arises a loneliness and an emptiness which they look to others to alleviate. But that loneliness may be so profound that it cannot be alleviated even by the best intentioned person. Women who suffer in this way are constantly vulnerable to disappointment and are liable to become resentful, chronic complainers. Such a woman is also liable to become dependent on drugs as a means of alleviating the pain of that loneliness. I do not intend to give the impression here that woman should not seek, even demand, to have their valid affective needs fulfilled. Indeed steps to do so in a direct way might be a healthy remedy for the syndrome to which I refer. However, I refer here to the fundamental need to claim one's own inner goodness, a risk and an act which woman must do for herself in order to deem herself deserving of the care and respect of others.

Goldstein also mentions distrust of reason as a feminine trait. This distrust is not without cause. Women have often had their feelings and intuitions discounted by the rationalizing male. This experience has led many women to distrust reason, even their own reasoning powers. They may allow feelings such as guilt and fear to immobilize them, not daring to act contrary to them even though their reason tells them the feelings are unjustified. They may also allow feelings to cloud their judgment both by being "taken in" by others and by judging others subjectively and

unfairly. They may also fail to value and use logical analyses of the irrationality of male supremacy as a weapon in their struggle for liberation, confirming themselves to emotional outbursts which dissipate rather than focus the energy of their anger.

Suffering and Women's Transcendence

Not only does the theology of sin need to be reformulated to include the human situation in terms of women's experience, the theology of suffering needs to speak more directly to women. Traditionally there has been a stereotypical way in which men and women were expected to respond to suffering--men were supposed to resist; women to accept. Resistance was a requisite for male dignity. Dylan Thomas articulates the ideology of male resistance to suffering with poetic persuasiveness in his poem addressed to his dying father:

> Do not go gentle into that good night
> Old age should burn and rave at close of day
> Rage, rage against the dying of the light
> .....
> And you, my father, there on the sad height
> Curse, bless me now with your fierce tears, I pray
> Do not go gentle into that good night
> Rage, rage against the dying of the light.[21]

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[21]Dylan Thomas: THE POEMS OF DYLAN THOMAS. Copyright 1952 by Dylan Thomas. Reprinted by permission of New Directions Publishing Corporation.

On the other hand, the ideal woman was expected to neither flee nor protest. She should accept and endure. In the second chapter of Cry the Beloved Country by Alan Paton, the author describes the pain and grief of a mother whose son has gone to the great city of Johannesburg and who has not been heard from for several years. She and her husband are finally facing the fact that their son will never come back. The husband, Stephen, leaves to pray in the church and

> . . . she watched him through the little window, walking to the door of the church. Then she sat down at his table and put her head on it, and was silent, with the patient suffering of oxen, with the suffering of any that are mute.22

At the end of Riders to the Sea, a play by the Irish dramatist, James M. Synge, the mother, Maurya who has seen the men in her family, all fishermen, lost to the storms of the Atlantic, stands over the corpse of her drowned youngest son. She speaks the closing lines of the play, "No man at all can be living for ever, and we must be satisfied."[23] No raging there against "the dying of the light." Though differing in race and separated in space, these two fictional

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[22]Alan Paton, Cry the Beloved Country (New York: Charles Scribner's Sons, 1948), p. 10.

[23]James Millingham Synge, "Riders to the Sea", in Bennett Cerf and Van H. Cartmell, Thirty Famous One-Act Plays (New York: Modern Library, 1943), p. 238.

women have one thing in common; they are by circumstances and culture conditioned to and expected to be passive and resigned in the face of suffering--to accept what they seem powerless to change. They are the daughters of the women who stood by the cross of Jesus--destined to bear and birth sons in the beginnings and to anoint them for burial with little influence on the social, economic, or political milieu which shapes their lives and, in many cases, determines their end.

It is not my purpose here to make a theological analysis of human suffering or to ask how one can reconcile suffering with a loving God. Rather it is proposed to take as a starting point the fact of suffering and to ask how the Christian is to find meaning in suffering, and how the Christian might respond to suffering in such a way as to incorporate it into the life-movement of the individual and the community.

Here is seems helpful to inquire into what the wisdom of the various religious traditions have to say about suffering, in order to find therein various possibilities of responding to it. As Edward Schillebeeckx says in Christ the Experience of Jesus as Lord, "Every man (sic) enters the world with a cry, and yet there is cause to rejoice! Suffering obviously has more than one face."[24] It also has more than one possible response.

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[24]Edward Schillebeeckx, Christ, the Experience of Jesus as Lord (New York: Seabury Press, 1980), p. 670.

Alternative Responses to Suffering

An unfortunate by-product of role-stereotyping is that is has limited the culturally acceptable responses of both male and female to suffering. It is my contention that dependency on prescribed drug is closely related to the cultural expectation that women endure suffering without protest or complaint, and that they dedicate themselves wholly to the alleviation of suffering in others. Prescribed drugs can for a time make it possible for a woman to cope with what she experiences as intolerable suffering while she tends to others.

Resistance to Suffering. However the history of human suffering offers other alternatives.[25] In Zoroastrianism (4 B.C.) and later in Manachaeism (267 A.D.) we find dualistic explanations of suffering. Zoroastrianism attributed good to a spirit of light and evil and misfortune to a spirit of darkness. Manachaeism evolved a spirit-matter dualism associating God and goodness with spirit and suffering with matter.

This sourcing of suffering in a principle apart from God, though it has undesirable dualistic side-effects, validates

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[25]See ibid., pp. 672-715 for an extended treatment of the theological history of human suffering.

the need to resist suffering as an evil by disassociating it from the principle of good. The difficulty of expressing anger or frustration in the face of suffering because to do so would be to blame God is a problem which troubles many sufferers. For many there is a taboo on resisting what is perceived to be the will of God. This attitude leads to passivity in the face of suffering. It is also an attitude which is exploited by oppressors in order to maintain a status quo which favors them. Women's "place" in the world is often defended as divinely ordained and of course there is plenty of support for this position in our patriarchal Judeo-Christian scriptures. Woman needs to free herself from the association of suffering with the will of God and to resist suffering and evil in ways other than, but not exclusive, of ministry to the sufferer.

The Exodus Response to Suffering. The prototypical response to suffering and oppression in the Old Testament is exodus. It offers to us the option of getting up and leaving the place of suffering and going into a better land. This "flight" from suffering is not just an escape from suffering but an escape towards a fuller life. This is probably one of the most difficult options for a woman. To simply leave the locus of her pain, especially if that involves leaving someone to whom she has made a commitment, seems like a betrayal. The woman trapped in a marriage to

an alcoholic spouse will often tell herself, "I can't leave; he needs me;" or "I can't leave; I need him to support the children."

Integrity in Suffering. Job's story also presents a model of integrity in suffering--a refusal to accept blame, to be satisfied with the cliches of a reified wisdom. Job is true to his feelings of anger, hurt and despair and, eventually, out of his fidelity to his own truth, a new hope is begotten. Women not only suffer from various personal and social conditions, they also, like Job suffer from blame--if she is raped, she asked for it; if she is battered, she deserved it. Sometimes women are told that the cause of their suffering is all "in the head." This is the basic premise behind the prescribing of tranquilizers to alleviate situational emotional stress. Job's refusal to yield to social pressure to deny his own experience is a good model for women.

Suffering in Solidarity with Others. Suffering in solidarity with others with a view towards the ultimate redemption of all from suffering is another alternative which is suggested by both the Marxist and Christian traditions. In the Marxist tradition suffering is seen as a sign pointing to social injustice. The individual sufferer may not have the strength to take steps to change the oppressive

conditions, but being part of a group who know experientially what the person is suffering brings her the collective strength of community. Moreover, taking part in a movement towards liberation in a group alleviates the sense of helplessness. (Twelve step groups have some of the qualities of liberation groups except that they do not engage themselves in changing social conditions.) Women, often feel isolated in their suffering, especially if they are drug-dependent. Experiencing solidarity with other women who have the same problem and working towards better medical care and better conditions for mothers and homemakers can be both empowering and healing.

In the Christian tradition the alternative of suffering in solidarity with others requires an inner faith in the power of grace to change people's hearts. To maintain this appeal to the heart it is necessary that those who suffer be willing to undergo the purification of their own motives. Such purification is necessary to prevent the sufferer from using the very methods of the oppressor in order to attain liberation. As I mentioned earlier in this chapter, women are sometimes tempted to assume the methods of the male-power structure in their attempts to liberate themselves, but these methods do not transform or liberate, they merely effect an exchange whereby the oppressed becomes the oppressor.

Finding Meaning in Suffering. In the Greek and Roman traditions human and divine suffering are a part of the universe, a part of the cycle of decline, death and rebirth. Various philosophies within these traditions attribute differing meanings to suffering. The cynics cherished renunciation and self-denial in service of human values. Stoicism held that the truly wise person is not affected by suffering because inwardly she/he remains dedicated to the true and the good. In these traditions we see the alternative of finding meaning in suffering which cannot be changed. Suffering in the service of a human value lessens the power of suffering over the sufferer by utilizing it. Fasts, vigils, imprisonment can sometimes be undertaken or borne joyfully in service of a worthy cause. The older Catholic tradition of offering sickness and bodily suffering on behalf of someone else (vicarious suffering) is a more traditional form of this type of response. Learning that one can handle suffering (when that suffering is not undertaken in a masochistic way) is empowering. The automatic prescribing of pain killers and tranquilizers, however, assumes that women cannot handle suffering, this in the face of evidence that women have been capable of enduring immense suffering bearing and birthing new life. The stories recounted in Chapter 1 give evidence that women recovering from drug-dependency can handle the suffering involved in

recovery and can face and handle life without those pills once deemed indispensable.

However, it is important that those who choose to suffer on behalf of a cause or for another person constantly assess whether the cause is worth the suffering. In this option there is always the danger that fanaticism may take over and that the cause may become more important than the persons on whose behalf it was seemingly pursued.

Meditation and Suffering. Eastern religions recommend inner tranquility as an antidote to suffering, claiming as they do, that one's attitude towards the world plays a large part in suffering. This response is particularly appropriate when the suffering arises from physical pain or some other cause which cannot be changed. The practice of transcendental meditation and yoga prepare the sufferer for the gift of inner tranquility and peace. The Jesus Prayer from the Eastern Christian tradition can also be practiced towards the same end.

Western discursive meditation is helpful in changing conscious attitudes. Through such meditation one can become aware of the extent to which one may share responsibility for one's own suffering or that of others. On the other hand one may also come to the realization that there are some sufferings (such as natural disasters) for which no one is immediately to blame. The ability to cease blaming

oneself and/or seeking a scapegoat can lessen the impact of suffering by restoring inner peace.

Compassion and Suffering. Yet another possible response to suffering is surrender. By surrender I do not mean passive acquiescence but an active participation in one's own suffering. Surrender involves letting go of futile struggling against it, owning it as one's suffering but doing so without self-pity. Such surrender opens the way to compassion, first for oneself, and then for all who suffer. Compassion differs from self-pity. In self-pity I stand apart from myself and say, "Poor me." In compassion I am at one with myself and my suffering. In compassion I am open towards others, vulnerable and ready to accept their care and love. In self-pity I am isolated, at one and the same time inviting and rejecting concern. Compassion transforms suffering into healthy love of oneself and others.

Women can exercise compassion towards themselves by taking their own suffering at least as seriously as that of others. This means that they cease to ignore their own suffering while they tend to that of others. It means honestly acknowledging their own need and seeking, even demanding that it receive attention.

Human Resources and Suffering. Using social, cultural, and scientific resources to alleviate or eliminate suffering is another alternative response. However women need to be aware that in their present state these resources have been mainly produced. developed and administered by males. They have, up to the present, added little to the quality of life; on the contrary they have in many instances diminished it. Psychotrophic drugs are a case in point. If their overall benefits were weighed against the massive physical and psychological problems which have attended their use there is little doubt as to where the balance would fall.

Women suffer from social discrimination in the job market as well as in the seats of government and in the professions. They need to work towards positions in which they can use their influence and actualize their values so that the intellectual and emotional and physical resources of the world may be rescued from the vassalage of profit and power and placed the service of interrelatedness and life. For example the seven women whom I interviewed have amassed a large and valuable amount of experiential wisdom regarding the nature of psychotrophic drugs, their abuse and the medical, familial, social and religious conditions which make that abuse a possibility for any woman. They and many others like them are in a position to educate other women and many doctors in the lore of their life-experience.

Social scientists need to understand what it is like to grow up female; psychologists need to discover who woman is by being told by women not by making assumptions drawing unwarranted conclusions from what is known of man (meaning men). The medical profession needs to learn about women's body from women. When women take their place in these institutions a considerable amount of suffering will be avoided.

Salvation from Suffering in the Cycles of Decline and Rebirth. The writings of the fourteenth century English mystic Julien of Norwich are not known well except for the statement which T.S. Eliot has made famous, "And all shall be well; and all manner of things shall be well." Coming from this woman this is not a pie-in-the-sky promise. It is, rather, a statement of "cosmic optimism,"[26] of the confidence in the yielding of suffering to joy and the rising of new life out of death which women have always known and of which this mystic was specially aware. We suffer because we have lost touch with our cyclic consciousness. Our images reflect this loss. We speak of hope as the light at the end of the tunnel, of rest as reaching the end of the road. We suffer because we travel

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[26]T.S. Eliot, "Four Quarters," quoted in Kenneth Leech, Soul Friend (San Francisco: Harper & Row, 1977), p. 147.

life in straight lines our eyes fixed on some distant goal ahead. The trouble with straight lines is that they go on and on, and that goal recedes as we advance. Not so in cyclic consciousness. There wherever we are is at once an end and a beginning.

Women who live the cycles of menstruation and childbirth and who have traditionally tended the birthing couch and the death bed know that indeed in the cycles of nature sorrow is turned into joy and life gives way to death and death arises again in new life. Women can teach the world their own unique response to suffering when they have reclaimed what they know. Carol Christ dreams of a time when we will have reclaimed that special knowing, and words her dream as follows:

> . . . I like to think of women's celebration of the body, nature, feeling, and intuition as the first stage in an attempt--which surely cannot be fully successful on the first try--to move towards a more whole way of thinking, I like to think that in this mode of thinking, the body, nature, emotion, and intuition will be affirmed, but also reason, freedom, and the spirit will not be left behind, I like to think about spiritual insights arising from connection to the body and nature, to imagine forms of understanding in which the body plays a part, and to begin to conceptualize a view of human freedom in which limitation by nature, death, and finitude is accepted.27

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[27]Christ, p. 130.

Christian Hope and the Transformation of Suffering

Erhard Gerstenberger says that suffering is the wellspring of hope. Without the experience of suffering in some form there would be no impetus to hope. Suffering, points the sufferer towards the future for it "stamps 'not yet' on the consummation of salvation."[28] It causes persons to watch out for the end of suffering. The death and resurrection of Jesus is the Christ event which guarantees the end of suffering--the triumph of life over death. This is an expression of the traditional theologies of hope.

However, in eschatology the implication is that the consummation of hope lies somewhere in the future and that one endures the present because it will eventually give way to a better time.

Christian hope, I believe, is not so much hope for the _end_ of suffering as hope for its _transformation_. In _The Crucified God_, Jurgen Moltmann says that the resurrected Christ "Qualifies the one who has been crucified as the Christ and his sufferings and death as a saving event for us and for many."[29] In other words, possibilities for life inhere in his suffering and death and these possibilities

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[28]Erhard S. Gerstenberger and Wolfgang Schrage, _Suffering_ (Nashville: Abingdon Press, 1977), p. 273.

[29]Jurgen Moltmann, _The Crucified God_ (New York: Harper & Row, 1973), p. 182.

are confirmed in the Resurrection, what is obscure and hidden in the cross is manifested in the Resurrection. This showing forth of life in death transforms death and suffering. The notion of transformation is more in harmony with the cyclic nature of creation than is the notion of and end to suffering.[30] The resurrection of Jesus is not just the transformation of those final moments of life into a fuller life; it is a transformation of his entire life, including the end.

As we look at Jesus' life we see that he did not just suffer, he responded to suffering in many of the ways mentioned earlier. He protested unjust treatment at his arrest and during his trial (Luke 22:52-53; John 18:19-24); he experienced hurt and rejection, and he wept over the rejecting city and over the death of a friend (Luke 19:41-44; John 11:35-37). He turned in fear and loneliness for support from his friends (Mark 14:37-42). He moved to another place to escape from those who wanted to kill him, (John 11:51-54; John 7:1), he actually protested the greedy exploitation of the temple, (Luke 19:45-46; Mark 12:15-19), he spoke against the unjust condemnation of the woman taken in adultry, (John 8:1-10), he communed with God at the height of his agony, and in the end he surrendered to suffering and death,

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[30] I suggest that the appropriate image of hope is a spiral terminating in a still point in which all of reality is united in dynamic harmony.

(Luke 22:44; Luke 23:46). His resurrection is not just the transformation of that last response to suffering but the transformation of all the various responses made during his life. The rising to new life is a sign of the openness to transcendence which inheres in every human response to suffering which is made in favor of life.

There are two fundamental ways in which hope is obscured. The first is expressed in the attitude that denies the presence of life in the present situation. This attitude takes the form of despair and physical or psychological suicide, or of endurance (with or without the help of a drug or palliative of some kind) while we await a future rescue. The other is the insistence that there is life where it is not, the misnaming of life. That is what has happened to women. The patriarchal culture tells her what is and what isn't life and it has deceived her. Together, women need to reclaim and share with one another their perceptions of their past, and bring to bear on the present the awareness which emerges.

Living Models of Hope

When they were asked what was most helpful in their recovery, all of the women interviewed mentioned someone, a doctor or a counselor who understood what they were going through and who could tell them, not just in words, but by

the witness of their own lives that they could recover, and were willing to help them in the recovery process. Hope for them was a person and a relationship. Through the influence of that model they were able to avail of further helps in uncovering the life which had been obscured for them.

For us women hope involves a collective search for the models that have been unspoken and unsung in our past. Already women are building a basis for hope in their research and efforts to uncover our lost history. There are also signs of hope in women's reclaiming of their own power, not the power to exploit, manipulate or win, but the power to co-operate and integrate. Hope calls old women to see visions and young women to dream dreams and to find the concrete embryonic shape of those visions and dreams in the womb of the present moment. Hope is not just in an alternative future but in an alternative present in which women may bring their wisdom to bear on a range of choices with which to respond to the obstacles as well as the opportunities for transcendence which life affords them.

In this chapter I have presented analysis and a critique of the constrictive elements of the theology of sin, suffering, and hope as it applies to women and I have suggested ways in which women may break through the confines of that theology and tend towards that openness to transcendent life which is a universal human heritage and their right. In the concluding chapter I will examine more concretely the

constrictive structures of the Catholic Church, discussing ways in which they may be changed, and suggesting ways in which the recessed life-resources in the Catholic Church may be placed at the service of women in general and of the drug-dependent woman in particular.

Chapter 5

RESPONDING TO THE PROBLEM OF DEPENDENCY ON PRESCRIBED DRUGS IN WOMEN

The Church which is called to make a pastoral response to the problem of drug-dependency in women is one which ministers to people in several ways: through sacraments and liturgy, preaching and teaching, through spiritual direction, and, to a lesser extent, formal counseling; and through organizing and administering. I propose in this chapter to explore how these various ministerial functions of the church might be enlisted in a response to a problem in such a way that not only would the problem itself be addressed but the ministerial role of the church would be enriched and the life of the local church community would be enhanced as a whole.

In the process of evaluating the resources of the church it will be necessary to critique current church policies and practices from a feminist point of view because without radical metanoia in regard to the unjust and repressive stance of the Church toward's women the recessed riches of the church cannot be uncovered and restored to the people of God.

The Problem as Symptom: Its Message to the Church

I look upon dependency on prescribed drugs not just as a problem which affects those who suffer from it and which calls for a cure and perhaps steps to prevent its occurrence. Rather, I first address it as a symptom which points to something amiss in the system and which calls for a thorough examination of that system and for consequent change. I will illustrate my approach by way of a parable. A certain man walking on the bank of a river which flows through an industrial area of the state noticed several fish lying dead on the bank and several others gasping in the water. The man hurried off, purchased a net, and a large tank. He returned to the river, captured the fish and placed them in the tank of fresh water where for several weeks he tended them with food and medicine. The fish recovered and became healthy. When they were quite well he returned them to the river where a couple of weeks later they died. A woman was also walking along the river and noticed the dead and dying fish. She hurried off to the environmental protection board and demanded that something be done about the pollution of the river. Within a year the pollutants had been entirely removed from the river, but by then most of the fish had died. Obviously the problem of the dying fish needed a both/and rather than an either/or response. In this chapter I will attempt to include features of both

types of response to the destruction of women by prescribed drugs.

The Problem in Relation to the Local Church Environment

The local church is a microcosm of the patriarchal universal Catholic Church. Its leaders are still an all male clergy, and that situation is unlikely to change in the near future. A radical feminist approach to problems occurring within such a structure might advocate that women simply sever relationship with it, claim their own power and proceed to do what needs to be done for the betterment of their own lives. While elements of this approach will be considered here, this radical stance as a whole will not be the guiding motif of my recommendations.

First such an approach would leave many women, and especially those likely to suffer most from the problem unhelped. Women who all their lives have sacrificed their selfhood in order to maintain a relationship with men are not likely to suddenly espouse and live a radical feminist philosophy. Secondly, I myself, do not see the liberation of women as a reality which can take place in separation from or in permanent antagonism towards men. Who we are, and who we become is always relational; relational to others, both male and female, relational to our past, individual and collective, relational to our present, and moving into a

relational future. I propose therefore, to consider the issue in such a relational context. Secondly, the structure of the local parish contains elements which if sufficiently "feminized" would provide a nurturing environment for both male and female members.

The Problem - Its Message to the Local Church

The problem of dependency on prescribed drugs, as symptom, speaks to the Catholic parish community on two levels which are distinguishable but not separable: the spiritual-cultural-social, and the spiritual-individual. Take, for instance, the woman who presents herself at the rectory door and says, "Father, please say a Mass for my intentions." She is shaking, there are dark rings around her eyes betraying insufficient sleep. She may be Bea, whose alcoholic husband has just died, she may be Joan, just arrived in the parish after her fifteenth move, she may be Margaret who has just lost her nurse's license . . . her "intentions" may encompass the story of any of the seven women described in Chapter 2.[1] She might be any woman in the average parish, because so far, there is no evidence

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[1]Though only one of the seven women interviewed had ever belonged to the Catholic Church, the Religious milieus of most of them was similar to that experienced by the average Catholic woman.

that the legal drug-dependent woman is significantly different from any other woman. Her self-image is role bound, her self-esteem is low, she is devoted to nurturing others to the neglect of herself, she is unable to be effectively assertive, she defers to male authority figures. She is any woman given a crisis and the discovery of the instant relief of a drug. The priest may say, "I'll offer the eight o'clock Mass tomorrow for you; goodbye and God bless you."--thereby confirming her notion of the Mass as a magical ritual not unlike the "miracle drug." The woman will return to the destructive life style in which she is trapped. Or he may invite her into the office, ask some questions about those "intentions" for which she wants the Mass offered, and may hear some or all of the story of a drug-dependent, or a potentially drug-dependent woman. Her symptoms like those of the dying fish in the river point to unhealthy environmental conditions, conditions from which the patriarchal system is profiting. They also point to a corresponding malignant condition in the woman's personal, internal ecology.

Conditions Which are the Ground of the Problem

Writers like Mary Daly hold that the oppressed condition of women arises originally and fundamentally out of and

is caused by patriarchal religion.[2] Since in primitive societies the entire culture was religious there is no doubt that her contentions are accurate. In contemporary society there are both a religious and a secular culture. However in regard to the oppression of women the Church has nothing over the secular world. In fact, in some instances secular society offers more liberating possibilities to women than the Church does. At least technically women are not debarred from positions of authority in secular government; they are in the Church.

My thesis here is that many of the oppressive attitudes and customs in the world had their origin in the Church and are still perpetuated in and legitimized by the Church. Hence the Church is responsible for cultivating the ground in which powerlessness and dependency in women thrives.

In this section the ground of the problem as it is manifested in society and in the local Catholic Church will be examined in terms of its oppressive and stultifying effect on women, and on their identity and self-esteem, possible remedies will be proposed, and that same ground will be explored for its growth potential.

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[2]See Mary Daly, Beyond God the Father (Boston: Beacon Press, 1974).

Women and the Nurturing Role

From infancy the girl-child is reared towards the nurturance of others. As Gwen Kennedy Neville says, "The process of invisible induction into socially approved ways begins in the bassinet. "Through the handling and treatment of little girls and little boys, the toys they are given, the way they are dressed, we know that culture is transmitted in invisible ways."[3] Girls are given dolls to dress and feed, miniature household utensils to use, they become mommies' little helpers around the home. As they grow older they are encouraged to enter the nurturing professions, becoming teachers, nurses, counselors, social workers (not doctors or psychiatrists, however). Their nurturing profession is of course only a temporary occupation which will keep them busy until the right man comes along, at which time they will submerge whatever identity might have begun to emerge by becoming his wife. The skills acquired in her temporary profession will of course be useful in child-rearing. During the child-rearing years the women will associate mostly with children, reducing her interests and conversation to their level. If she meets with other women, the conversation will center mostly around child-rearing. This exclusive orienta-

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[3]Gwen Kennedy Neville, "Religious Socialization of Women," in Alice L. Hageman, Sexist Religion and Women in the Church (New York: Association Press, 1974), p. 80.

tion towards nurturing of others is particularly apparent in the women's stories recounted in Chapter 2. Bea had not finished rearing her own children when she took on the care of her grandson. She was isolated from other adults outside her family. Her husband forbade her to get a job though she wanted one. She was intensely involved in the marital problems of her adult children and there was little emotional support from her alcoholic husband. It was not until she was in a group at the hospital during her recovery that she discovered that other families have problems too. Overburdened and isolated, she finally screamed, literally, only to have her scream stifled for ten years by tranquilizers.

Joan's goal was to make her husband happy at whatever cost to her own happiness, childrearing was left to her and that included responsibility for a rebellious stepdaughter. Ellen found the rearing of her two children a burden, especially as there was no help from her alcoholic, chemically dependent husband who, as she said, was no better than another child. Linda had taken on childrearing when she was a teenager and was a mother to her three younger brothers. Margaret loved her children and states that she and Ray had one strength, they were good parents. However after the birth of the fourth child in six years, she felt that she had had enough, she was tired. When she got work at a hospital and was really enjoying the association with other women her work career was soon cut short by her husband's male psychi-

atrist who summoned her for an interview and, in the presence of her husband, issued the ultimatum that she must quit work--it was upsetting Ray too much. So she deferred to his need and became a fulltime housewife again. None of these women believed that she had any option. There was no question of acting counter to role expectations. Moreover, with the exception of Margaret, they had been unnurtured themselves as children in alcoholic families or reared by rigid and overly strict parents.

On the whole the Catholic parochial ideology and system reenforces and legitimizes the one-sided nurturing role of the woman. In the average parish it is assumed that nurturing tasks in the parish will be performed by women. They will run the nursery co-op during Sunday Masses, teach Religious education classes, bake cookies and cakes for fund-raisers, cook hot-lunches, prepare and serve the coffee and donuts after Mass, wash the altar linens, decorate the altar and clean the sanctuary. But they will not preach, administer the sacraments (or in many parishes) read the Word of God in Church except in the absence of a qualified male.

It is argued that much of what I describe has changed, that we have "come a long way" towards equality. Examples of parishes where women are Eucharistic Ministers will be cited but it must be noted that such parishes are not too common and that the presence of women in the sanctuary for

reasons other than cleaning is achieved by judicious maneuvering around papal and diocesan rules. Little girls still ask why their brothers can be altar servers and they cannot and the only answer is "Because you're not allowed . . . you're a girl."

In "Religious Socialization of Women in the Church" Gwen Kennedy Neville recounts an anecdote which illustrates the two steps forward one back motion of the churches towards equality for women. She describes how in 1976 she was particularly impressed by a female friend who has completed a B.D. at a reputed school of theology, had served as associate pastor and had married a classmate who was also a pastor. "She was intelligent, charming, and had a good job doing interesting things." After six years she met the same woman again. She was now a housewife and mother, working in volunteer groups while her husband taught on the faculty of a southern state university. Both had been honor students at seminary, He went back for a Ph.D. while she had two babies, He interviewed nationally and found a good job as an assistant professor, while she moved with him. He writes, lectures, books, articles, thinks about important things, while she donates her time at the church . . ."[4] The story might be repeated with appropriate adaptations if we were to consider the abilities and education of Catholic

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[4]Ibid., p. 87.

sisters (on the whole the best educated group of women in the U.S.) with the abilities and education of priests and note the discrepancy in the amount of power and influence which exists between them in the Church. The same story is lived out over and over in the lives of laywomen. Even the professional laywoman who continues to practice her profession after marriage and childbirth does so at the expense of great inner and outer conflict, haunted by explicit an implicit reminders that her children are being neglected and that she is about to lose her husband to someone who will "treat him like a husband" and not dominate him.

The first message which the Church is given by the presence of dependency on prescribed drugs among its women members is that the entrapment in a role which condemns them to always putting the nurturance of others ahead of their own is so stultifying and painful that some women cannot bear it unless they are tranquilized into insensitivity.[5] This fact remains true even if women profess to be satisfied with their role and are unwilling to change it. One of the greatest injuries of stereotypical roles is that severe

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[5]There is some evidence that drug-dependent women come from the ranks of the traditional "housewives," not from that of women who combine homemaking and career. This evidence is cited in Patricia Sutker, "Drug Dependent Women, an Overview of the Literature," in George W. Beschner, et al. (eds.) Treatment Services for Drug Dependent Women, (Rockville, MD: National Institute on Drug Abuse, 1981), p. 31.

stigmas are attached to those who violate them. Consequently it is unthinkable for many women that they should behave in any way other than that which the culture, supported by the church prescribes. As one woman put it, "The greatest tragedy is that we believed what we were told about ourselves."

The Ideally Feminine

The second message which the presence of drug-dependent women in our midst gives to the local church is that women suffer severely from what I will call the ideal image stereotype and that women who sacrifice themselves to maintain that image are candidates for prescribed drug-dependency. The qualities of this ideal female are best described by Sandra Bem in an article based on responses to a questionnaire given to undergraduates, male and female at Stanford University in 1974. According to these findings, the ideal woman is affectionate, cheerful, childlike, compassionate, flatterable, gentle, gullable, loyal, sensitive to others, sympathetic, understanding, warm, yielding and soft-spoken. She does not speak harshly and she is eager to soothe hurt feelings, she loves children. Qualities considered incompatible with her feminine image are assertiveness, ambition, aggressiveness, dominance, independence, self-reliance, self-sufficiency, strength, forcefulness. Qualities such as willingness to take a stand, risk, lead, to defend

her own beliefs, and to be decisive are considered less important for her than for a male.[6] Inge K. Boverman, et al., found that psychologists and psychiatrists considered the well-adjusted woman to be more emotional, more submissive, more excitable in minor crises, less independent, less competitive and less objective than the well-adjusted male.[7] Suzanne Keller puts the picture together in six basic tenets which mark the acceptable feminine role:

1. a concentration on marriage, home, and children as the primary focus of feminine concern.

2. a reliance on a male provider for sustenance and status. . . .

3. an expectation that women will emphasize nurturance and life-preserving activities, both literally as in the creation of life and symbolically, in taking care of, healing, and ministering to the helpless, the unfortunate, the ill. . . .

4. an injunction that women live through and for others rather than for the self. Ideally a woman is enjoined to lead a vicarious existence--feeling pride or dismay about her husband's achievements and failures or about her children's competitive standing.

5. a stress on beauty, personal adornment, and eroticism, which though a general feature of the feminine role, is most marked for the glamour girl.

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[6] Sandra Bem, "Androgny vs. the Tight Little Lives of Fluffy Women and Chesty Men," Psychology Today (September 1975), 58-62.

[7] Inge K. Boverman et al., "Sex Role Stereotypes and Clinical Judgements of Mental Health," Journal of Consulting and Clinical Psychology 34 (1970), 1-7.

> 6. a ban on the expression of direct assertion, aggression, and powerstrivings except in areas clearly marked woman's domain--as in the defense of hearth and home. . . .8

The seven women whose stories are recounted in Chapter 2 would score high in the ideal woman scale. They are dedicated nurturers, they are compliant, or were, until sheer survival forced them to assert themselves. It is questionable whether many of them would even yet be willing to risk self-assertion beyond what is necessary to remain drug-free. They still feel more secure in the traditional feminine role. All reacted negatively to the more assertive aspects of feminism.

The Church and the Feminine Stereotype

The stereotype which still epitomizes femininity is identical to that of the good Catholic woman epitomized in the standard Catholic image of Mary, the Mother of God and the Catholic woman saints. With the exception of eroticism (the beauty and personal adornment is spiritualized represent the inner adornments of chastity, meekness and modesty) the traits match the litany of Loretto in praise of Mary, "Mother most pure, mother most chaste, virgin of virgins, mother

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[8]Suzanne Keller, "The Female Role: Constants and Change," in Violet Franks and Vasanti Burtle (eds.) Women in Therapy (New York: Brunner/Mazel, 1974), pp. 417-418.

most amiable, mother most admirable, health of the sick, refuge of sinners, comforter of the afflicted." The parts of the litany which make her Queen of patriarchs, prophets and other male figures is not proposed to the Catholic woman either for understanding or emulation. In general qualities which denote strength courage and risk in such saints as Joan of Arc, Teresa of Avila and Catherine of Siena are explained as ideocyncratic quirks in spite of which they are holy, or accidents of time and place no longer relevant to contemporary women. Today when a Catholic Sister confronts a pope on behalf of justice for women in the Church she is anathematized not canonized. It is not surprising that the contemporary Catholic heroine is Mother Teresa, much lauded for her nurturing and care of dying Indian babies, poor, humble but especially a "loyal daughter of the Church" who never raises her voice against injustice anywhere not even against the system which produces the poverty and human degredation she seeks to alleviate.

Programmed Subservience

Quite recently I had an experience which constituted a vivid animated cartoon of how Catholic women have internalized the authoritarian patriarchal message of the central act of Catholic worship. I was attending a Saturday noon Mass in a local Church. There in the sanctuary stood a male

celebrant surrounded by a male lector, a male deacon and several altar boys. At the time for the sign of peace the celebrant, either by accident or design omitted to announce the customary invitation, "Let us offer one another a sign of peace." I turned to a woman beside me in the pew and stretched out my hand. She stood stiffly, hands rigid by her sides and shook her head saying, "No, Father doesn't want it; he didn't tell us," thus the sense of integrity, self-esteem and autonomy as engendered in the Catholic woman by centuries of male clericalism. Just as that woman would not dream of questioning the dictum of Father in the Church, she would not dream of questioning the infallibility of the representative of the patriarchal medical system. Father and doctor know best. The Church and the medical system have equal part in begetting the conditions of drug-dependency.

A common side-effect of the abuse of tranquilizers which is noted in the literature and verified by the women interviewed is the drastic reduction of the sex drive. While the women freely acknowledged this effect they said that they were not much concerned about it, assuming that it was just the result of aging. Anyhow, they could still perform sexually and "fake it." One wonders if a male would accept impotence as a side-effect of medication so casually. Obviously there would be a difference in his ability to "perform." However, the issue goes beyond performance to

the question of women's attitude towards their sexuality (as something for the production of babies and the pleasure of the male, but not for her own satisfaction) and the ways in which their attitudes have been and continue to be shaped by the Church, universal and local.

Another issue of concern is the relationship between negative attitudes towards her sexuality and low self-esteem. In "Judaeo-Christian Influences on Female Sexuality," Dorothy Burlage says:

> It is important for women and men to take seriously what the Judaeo-Christian tradition says about women and sexuality because the church, as the "guardian of public morality" has been crucial in shaping sexual and social behavior in both civil and religious institutions. Religious influence is conveyed directly to young girls and adult women through sermons, religious training, and Bible study. . . .
>
> Consider what a young girl might hear about women in church and how that might contribute to her identity as a woman. . . .9

Burlage goes on to catalogue quotations from the Old and New Testaments which relate childbirth pains to punishment for sin, indicate that the husband "shall rule over" the wife, refer to the wife as property akin to ox, ass, field, and house; legislates about marriage prices for virgins, warns young men against giving their strength to a woman, states

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[9]Dorothy D. Burlage, "Judeo-Christian Influence on Female Sexuality," Hageman, pp. 94.

that women should be subject in everything to their husbands and ends with that chauvinistic masterpiece from 1 Timothy.[10]

> . . . . Let a woman learn in silence and all submissiveness. I permit no woman to teach or to have authority over men; she is to keep silent, For Adam was formed first, then Eve; and Adam was not deceived, but the woman was deceived and became a transgressor, Yet woman will be saved through bearing children, if she continues in faith and love and holiness with modesty. (1 Tim. 2:10-15)

Dorothy Burlage goes on to say that taboos about menstruation in the Old Testament have stigmatized women as "unclean" and that Pauline texts in the New Testament carry an anti-sex, anti-marriage message and suggest that the really devout will not marry at all but lead celibate lives. Both Old and New Testaments allow a double standard wherein women are punished more harshly than men for nonmarital sexual activity.[11] Moreover, as Burlage points out, the Kinsey research reveals that of all influences on women's sexual patterns religion is the single most important. "Religious backgrounds of the females in the sample had definitely and consistently affected their total outlet after marriage. In nearly every age group . . . small percentages of the more devout and larger percentages of the inactive groups had responded to orgasm after marriage."[12]

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[10]Ibid. p. 95.

[11]Burlage, p. 99.

[12]Alfred C. Kinsey, et al., Sexual Behavior in the Human Female (New York: Pocket Books, 1953), quoted in ibid., p. 100.

Joan Ohanneson speaks of the subject of religious repression of women's sexuality from within the Catholic Church itself. She imagines a woman standing before a mirror, naked looking at her body "for once without guilt, without shame, without fear of punishment."[13] She asks herself how she feels about what she sees. She is not accustomed to asking the question.

> For centuries, the question has been asked and answered for her by others--primarily the wise and good and holy men in the church. They have described her, defined her, instructed her, legislated for her without ever once consulting her, ("What do you need? How do you feel? What do you think?")
>
> Officially, the churchmen demanded that she be saintly and emulate the Blessed Virgin, but theologically, in eliminating her from the decision-making process and in describing her as "defective male" and "full of filth" she was imaged, historically, as everything from a simpleton to a whore.14

It was, as Ohanneson says, a setup for schizophrenia. She was expected to repress and deny her sexuality before marriage and then to come to the marriage bed with passionate enthusiasm. There were those veiled messages that she was protector of the boy's purity and the-not-so veiled warning that if the boy goes too far it's always the girl's fault. It was her fault too if after marriage she did not get pregnant

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[13]Joan Ohanneson, Woman Survivor in the Church (Minneapolis: Winston Press, 1980), p. 21.

[14]Ibid., p. 22.

or got pregnant too often--a somewhat lesser evil. She was caught between rhythm and bi-yearly pregnancy, and being an experimental guinea pig for the various versions of the Pill which might give her cancer, make her sterile or cause her to hemorrhage to death or give her a heart attack thereby catapulting her before her maker in the state of sin for using contraceptives. Doubtless, membership in the Catholic church is not calculated to make a woman feel good about herself. Five of the seven women interviewed described their memories of church as full of don'ts, and though they deeply yearned for and sought a personal and fulfilling relationship with God, they did not expect to find it in any church, whatever the denomination. Those who were currently finding support and spiritual nurture in a church did so because of the sense of belonging, warmth, and fellowship they experienced.

The Single Woman in the Church

There are more than twenty-eight and a half million single women in the United States (unmarried or formerly married). They are what Joan Ohanneson calls "shadow women." ". . . they cannot be categorized into tidy theological cubbyholes;"[15] they do not derive their identity from a man.

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[15]Ibid., pp. 22-23.

Neither the Church nor secular society knows what to do with them. There was a time when their singleness was defined as a transitory state between young girlhood and marriage unless perchance "they were not lucky enough to meet the right man" in which case they became priests' housekeepers or someone's maiden aunt. More and more single women are refusing to be thus discounted. Within the ranks of the single are single mothers, widows, divorced, lesbians, unmarried heterosexuals who live with men. All have differing needs but they share a common one--the need to have an identity and a sense of meaning in their lives. Theologically, the Catholic Church has a place for women only if they fall into the category of virgin or mother. All others are theologically illegitimate. From the ranks of the single also come the drug-dependent and the potentially drug dependent.

One of the greatest stumbling blocks to the unfolding of women as autonomous selves is the image of God as male. We are told that we are made in God's image and likeness and that we are invited to become perfect as our heavenly Father is perfect. That image leaves us the choice between tending towards the impossible, a fully developed male or accepting what the church has been telling us all along that we aren't really made in God's image, that we should give up the effort and settle for what Paul has recommended anyhow--reflecting the glory of some male. How can we in fact believe that as Rahner says we are openness towards the transcendent when in

fact that transcendent is reflected to us in what we aren't and never can be. As Mary Daly says in Beyond God the Father the Christian God is fundamentally destructive of women. It might seem an exaggeration to say that women become drug dependent because the Christian God is imaged as male. However, when we trace low self-esteem in women as a group, and their ingrained deference to the authority of men, both traits find their genesis in the fact that they are born into and baptized into a religious system which radically legitimizes male supremacy and marks women as innately defective humans.

Understanding and Counseling the Alcoholic

Howard Clinebell refers to certain conditions in society and family as "the soil of addiction."[16] I submit that for a woman to be Christian and Catholic is to be rooted in the soil of dependency. If the Church is to respond adequately and honestly to the problem of drug-dependency in women it must own how profoundly that soil is contaminated.

In the preceding part of this Chapter, I have discussed drug-dependency in women as a symptom which leads

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[16]Howard J. Clinebell, Jr., Understanding and Counseling the Alcoholic (Nashville: Abingdon Press, 1968), p. 43.

us to look at what blocks the growth and development of women. I will now consider what would constitute an effective response to the problem at that fundamental level. First, just as in a twelve step program, the first step is acknowledgement of one's addiction and one's powerlessness over it; so too there is a fundamental need for a similar acknowledgement on the part of the Catholic Church regarding its addiction to power which causes it to keep more than half of its members in a position of radical subordination. On the parish level the immediate representatives of that power are the priests. An adequate pastoral response to the problem of dependency on prescribed drugs on the part of women requires first an openness to radical conversion from sexism on the part of priests.

First let us consider what is involved in such a conversion by considering the three levels of sexism by Daniel Maguire in "The Feminization of God and Ethics." Level One Sexism is represented by an excerpt from an editorial in The New York Herald Sept. 12, 1852 which refers to women as inferior "just as the negro is and always will be inferior to the white race and therefore doomed to subjection, but happier in that condition because it is the law of her nature." Level Two Sexism is represented by George Kennan who, almost a century after that editorial, wrote warning against making "constant attempts at moral appraisal" in the analysis of international politics.

Instead Kennan recommends confining moral issues and concepts to "the unobtrusive, almost feminine, function of the gentle civilizer of national self-interest in which they find their true value." Second level sexism sees women as the unobtrusive, unquestioning civilizer of the masculine world of power. This attitude might be called pedestal sexism. Level Three Sexism repudiates the first and second levels, "eschews sexist language, accommodates to affirmative action, holds no meetings in states that have rejected the ERA. Yet with all of this . . . it avoids baptism by total immersion in feminine liberation." The third level sexist believes that the liberation of women is a cause which should be struggled for and suffered for by women and he wishes them well in the endeavor. As Maguire put it, third level sexism misses the universal implications of this fundamental human sin.

> If the essential human molecule is dyadic, male/female, the pervertion of one part of the dyad perverts the other. And to distort femininity and masculinity, the constitutive ingredients of humanity, is to distort humanity itself . . . here is the original sin. Here is the fundamental lie that will have to mark all human ideas, customs and institutions.17

Some, (perhaps more than we care to believe) of the male church are either explicitly or implicitly at Level One; and fundamentally, that is the level from which most hierarchial

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[17]Daniel C. Maguire, "The Feminization of God and Ethics," Christianity and Crisis 42 (March 15, 1982), 15.

decisions are made. A larger group are, perhaps, at Level Two, on the institutional level, that is the public relations face of the Church. A few, hopefully are at level Three. In a harsher, but more realistic vein, I might say that all are at Level One, Two or Three depending on the extent to which a particular statement or action of women poses a threat to male power and supremacy. Conversion would require an acknowledgement of the truth of the oppression of women--all women--not just the poor, the third world woman, the battered, or the educationally deprived. That to use a Maslowian term is D (deficiency) level of oppression which certainly affects a large percentage of women. But all women are oppressed at the B level (being)--the level of freedom to become and to be fully human.

Secondly, powerlessness over that oppressive condition must be owned. Acknowledgement of the problem without owning powerlessness is insufficient; that is simply a form of the assumption that once we see the problem we can fix it. The oppressor is not called to re-assume power by "fixing it" but to make "a moral inventory" of the injustice done to women and try to make amends. Making amends is aimed more at symbolizing a radical change of heart, than at remedying the situation. The remedy lies rather in the transformation of human consciousness and the humanizing of the world. Such humanizing requires the involvement of women in all

aspects of human affairs, especially those most dominated by patriarchal structures and symbols.

The Contaminated Resources of the Catholic Church

The Catholic Church has at its disposal a variety of potentially rich resources for the spiritual nurturance and growth of person. However, these resources have been denuded of their nurturative power by centuries of patriarchy.

In the United States the local Church has claimed and exercised considerable control over the education of children, through the Catholic School system and the religious education of children in public schools. Mandatory religious education has been a prerequisite for access to the sacraments of Penance, Eucharist and Confirmation. Moreover, the educational system has been largely in the hands of women of whom until recently most were Sisters. However Catholic schools have been more remotely controlled by male run chancery offices and the content of the Catholic school curriculum as well as the content of religious instruction has been carefully monitored to exclude anything not in line with official Church teaching. To date, Catholic education has done little to educate towards equality and justice for women or to open up to its recipients the riches of our foremothers both secular and religious. For example the cult of Mary as well as that of the many female Catholic

Saints has been carefully sterilized of its rich but hidden woman-spirit and power. Male values of competition, success and technical efficiency have been inculcated over the more humanizing values of co-operation, playful creativity and other holistic, right-brain functions. Its aim has been to produce what one commentator called "tight little Greek minds" rather than to provide an environment for the unfolding of persons.

Women Helping Women

The expression "women helping women" is often understood to mean women ministering to women in a practical way. However, though that notion is not excluded from the term as it is used here, it means something more. It has been said that no individual or group has been known to relinquish power easily and it is not expected that the Catholic Church is any exception. We women will have to demand and insist on justice and we will suffer pain, misunderstanding and rejection in the process. It is here that women need to support one another in solidarity. Perhaps the most painful experience for a woman when she cries out for justice is to receive opposition from another woman. So thoroughly have we women internalized what they have been told about ourselves, and so thoroughly have we been welded psychologically and economically to males, that it is very difficult to some

women to even begin to see the oppression under which they labor. Women must support one another in claiming their own power to effect change even if that means temporarily separating themselves from male structures which oppress. This solidarity with other women is a significant Christian way of transforming suffering by embracing it as the price of becoming ourselves.

Potential of the Educational System

The Catholic educational system has access to an area rich in its potential for influencing values. It has the freedom from secular state restrictions to deal directly with spiritual and religious values. It has available a body of, on-an-average, the best educated women in the nation. Here, unfortunately, the level of consciousness of woman's issues among Catholic Sisters, though improving, leaves much to be desired. Most Religious Women's communities have, in their traditions, however, precedents in prophetic stances both in regard to the secular world and the Church from which they might regain courage. This body of women might become a potent force for change within the Church as well as a support for their sisters both married and single.

Parents are involved in the sacramental preparation of their children at times when it would be appropriate to educate both them and their children in the abuse of drugs both legal and illegal. They might also be educated in the

ethical and spiritual implications of drug use, alternative ways of coping with pain and theological issues related to suffering.

Catholic parishes are large--too large for sufficient personal contact between the priests and those to whom they minister. However, each Sunday more than one thousand people attend Mass in the average parish church. Here is an opportunity to reach a large number of people in a regular and on-going program of sermons. Unfortunately according to Church law only priests or deacons are permitted to preach at Mass and since these are products of and members of a hierarchial male caste system the possibility of the laity hearing anything prophetic about social justice as it relates to women is minimal. What people hear is the Word fashioned by a patriarchal culture, interpreted by representatives of a patriarchal Church.

Nelle Morton sketches different possibilities in "Preaching the Word" and I will use her imaginative sketch to suggest other possibilities for the Catholic Church.

> Consider what might happen with women in the holy places: behind the pulpit, proclaiming the Word, breaking the bread, consecrating the elements, baptizing, burying and marrying!
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> By her very presence a woman would confront the church daily with its own baptism. As preacher she might serve as catalyst for unleashing the imagination of the people for all kinds of creative ministeries, new styles of relatedness, of being present to one another, gifts of grace to one another. The entire laity might just come to know itself as

> ministry--a people of God in the world in the truest and most radical sense. The new language and new speech emerging out of such common involvement in ministry, listening, and living might furnish a new kind of movement and song for celebration. And then celebration could indeed become the work of the people, rising out of the heart of a people rather than structured from above.
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> Once the pulpit is de-sexed it can no longer be labeled as the phallic symbol in the sanctuary with the Book on top to give it authority. Women would more than likely carry the book down among the people, open it, saying, "See . . . see for yourselves! Read! How do you read? See . . . see even here seeds of liberation long ago overlooked by a patriarchal mind-set and culture."18

And I will add, what if that were a married woman? a black woman? and Indian woman? a Chicano woman? Not only would the liturgy become more humanized but woman, young and old would know that godhead and godheart is re-presented in the lineaments of her female flesh.

Growth and Healing Potential of the Sacramental System

The Sacraments are a rich heritage of the Catholic church. They mark times of crisis and growth stages in a person's life and they also bond the person to the transcendent in and through symbols within the faith community. Each provides a rich opportunity for experiential learning.

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18 Nelle Morton, "Preaching the Word," in Hageman, p. 34.

Baptism. Baptism which marks the initiation of the new-born into the community of faith is an event which can be utilized to support parents and other family members in the crisis of adjusting to a new member in the family. The pre-baptism preparation for parents and sponsors can be conducted by other parents in the parish who can give both psychological and spiritual support to new parents. This is a time when both parents might be encouraged to share equally the joys and burdens of childrearing thus relieving women of the excessive burden of nurturing which has been their lot. The ceremony of baptism which involves symbols of community should mark a beginning of on-going community love and support. Unfortunately the enthusiasm with which the new member is welcomed into the Church is not carried through in on-going support of the family.

Crises points in family life are times when some women begin to use minor tranquilizers. Joan, for example, received her first prescription to help her deal with the stress of coping with a new-born and the entrance of a pre-teen stepdaughter into the family. Then and throughout the child-rearing years, her husband left all the child-rearing to her. Though she was constantly active in her church, directing the choir, taking part in church-sponsored social activities, at no time did she receive any help with her family or in her personal spiritual life. Unfortunately, even though the revised rite of baptism in the Catholic

Church makes possible an enriching and supporting experience, in practice it is carried out in a perfunctory manner by an overworked priest who has not the skill or perhaps the inclination to involve the laity in the process. Many Catholic women may duplicate Joan's experience and turn to the pill bottle rather than to the sacramental Church for help.

Reconciliation. The Sacrament of Reconciliation (formerly called penance) has in recent years focused more on the social, interpersonal dimension of sin as a corrective for the former one-sided vertical view. However, whereas the theology of this sacrament has broadened, the ritual has not yet been fully exploited for its possibilities for healing within families, and between friends and neighbors. The possibility of the sacrament being celebrated within a family as a group or with a married or engaged couple has not been explored. Communal celebration in a parish are usually held during Lent and Advent however, the group is usually too large and impersonal for those participating to really experience reconciliation with one another. In effect, the ritual still remains oriented towards vertical reconciliation with God. The sacrament might be made more concretely effective if it were taken into the home and to the work-place, where people actually hurt, wound and offend one another. Moreover if the sacramental ministry of reconcilia-

tion were extended to women, married and single, and to married men, people would have a choice of ministers and a better chance of finding one attuned to their life-experience and life-style. Women in particular frequently find confession to a man embarrassing. They sense or fear that they are being pre-judged or interpreted in light of a male stereotype of women, or having a masculine understanding of life imposed upon them. Often, in the confessional a woman finds that the very movements towards health and growth are labeled selfish and sinful. Possibly, the role of the priest in the confessional has done more than anything else in the church to re-enforce low self-esteem and guilt in women. For women the sacrament is seldom a healing experience of being really understood and yet being challenged to grow according to the wisdom of her being.

Yet, administered by women and men who are sensitively in tune with the dynamics of women's growth the sacrament might be a prime vehicle for a woman's reconciliation with herself and with others. It might also serve the needs of families for opportunities to be reconciled to one another. On-going unresolved antagonism and hostility like that experienced by Joan in her relationship with her step-daughter and the painful experience of alienation between Bea and her son cause some women to seek relief in drugs, which rather than healing, cause further estrangement. An expanded and creative use of the sacrament of reconciliation

would indeed be a spiritually enriching and truly healing alternative.

Eucharist. The Eucharist is the celebration of oneness in the Body of Christ. It is at once a celebration of the actual and the possible, and an empowerment of those who participate to continue to make the possible more and more actual. It brings together in ritual all that the Christian community professes to be. In the Catholic Church the Eucharist is celebrated daily thus highlighting the central significance of community in the life of the people of God. Unfortunately, the exclusion of women from ordination, and the exclusion of the divorced remarried from participation in the Eucharist often makes of this Sacrament a poignant countersign of what it represents. Women who are excluded suffer most because of their need for relatedness. The Eucharist calls the Catholic community to make real in everyday life what is celebrated sacramentally.

Many women suffer from isolation, trapped at home with little opportunity to communicate with other adults much less to receive their support. The drug-dependent woman is particularly isolated doubly trapped in her life-situation and in her dependency. For her in particular the church needs to make the Eucharist an actuality not just a ceremony. Steps might be taken in this direction first through education towards a better understanding of the

relationship between Eucharist and life and secondly by celebrating it in such a way that it is more closely connected with actual experiences of love and support between those who participate.

Confirmation. Confirmation is celebrated in the Catholic Church at the beginning of adolescence. It marks entrance into adulthood in the Catholic Community. While there is some controversy about the appropriateness of the timing of the sacrament at the age of thirteen, its placement in the adolescent years does coincide with a crisis point in the adolescent and in the family.

Confirmation has traditionally been the sacrament in which the Holy Spirit was said to be received in a special manner. The theology of this sacrament has been a matter for debate, containing as it does ambiguities and contradictions. From a feminist point of view the life-giving and life-nurturing spirit is already present in each person. What the ritual of the sacrament should do is affirm and evoke that spirit, rather than impose it from above. The preparation for confirmation, then, might be oriented towards evoking and affirming the full vitality and goodness in the confirmandi. Among other things, that would involve making it a high point in the life of a girl growing into young womanhood. Preparation would augment her understanding of her self as body-spirit, her sexuality, her emotionality,

her intellect, not through abstracted theoretical knowledge or scientific charts, but through an imparting of woman's wisdom and lore from mother to daughter, from female teacher to younger friend. It would be a time to help the young woman to get in touch with the wisdom of her own body, heart and mind as a source of self-nurturance and of ministry to others.

At that age young people are beginning to separate out from the family, and they need help and guidance in their search for personal identity; likewise parents need help in parenting during those ambiguous years. Sacramental preparation can include such help as well as opportunities to discuss and share experiences with other parents with more or less experience of navigating their way through these often stormy seas. Mothers of adolescents are sometimes beginning to experience the "empty nest" syndrome with its attendant crisis in meaning. In particular women who have not prepared for or pursued a career are vulnerable to a severe crisis in self-esteem if they have lived vicariously through their children. This is a time when women may become dependent on drugs to alleviate existential anxiety. This particular type of anxiety is particularly ill-served by being silenced temporarily with tranquilizers. This sacrament might well be an occasion for the discovery of an expanded meaning of selfhood for the mother and might incorporate a

concomitant religious celebration of a parental rite of passage too.

Matrimony. The Sacrament of Matrimony celebrates the covenant of love between a woman and man. Marriage preparation can, if undertaken in time, provide the couple with an opportunity to discuss in the presence of a third person, who may act as facilitator, the implications of their commitment in areas including sex, mutual affection, children, relationships with inlaws, finances, issues which involve both the separate identities of the individuals as well as their life together. Too often couples enter marriage without having a clear idea of the terms of this important life-contract, only to find a few months later that each had a different set of assumptions about what they were vowing. This is a time when sex-role stereotyping should be challenged. A woman in love is liable to defer to the man she loves, influenced, no doubt by cultural admonitions regarding what qualities are necessary to get and keep a husband. Joan is an example of this conditioning. She entered marriage determined to make her husband happy. She never dared to test their relationship by asserting herself or demanding that some of her needs be fulfilled. In the end she needed an almost toxic level of alcohol and tranquilizing drugs in her system to help her maintain this stance.

The priest who witnesses the marriage is by right of his office often in a position to keep contact with the couple after the marriage and to give support and counseling during the first year when adjustment crises occur. Unfortunately most priests lack both the time or the training to carry through. Moreover, the sexist biases of many priests makes it more likely than their involvement in marriage preparation and follow-up will re-enforce sexism rather than help to nurture liberating marriages.

In third world countries, owing to the scarcity of priests, Catholic Sisters are officiating as Church witnesses in the celebration of the sacrament of marriage. It seems that for reasons other than scarcity, competent women should be involved similarly in marriage preparation, celebration, and follow up in every country.

Anointing of the Sick. The Sacrament of the Anointing of the Sick brings ritually the support, and spiritual healing of God through the community of the Church in the crisis of physical or emotional illness. When sensitively carried out it brings to the sufferer a sense that being weak and vulnerable not only does not exclude her from the community but rather surrounds her with their love and concern and reassures her that she belongs there. This, I might say, is the most tender sacrament of the Church. Whereas formerly this sacrament was reserved for those in

danger of death, it is now available to all who suffer from any illness which seriously affects her/his life. It carries with it the opportunity to minister not only to the sick but also to their families. Here is an opportunity to help the sick person confront and work through proximate and ultimate issues connected with serious illness and possible death. The anointing of persons who are struggling with chemical dependency can help alleviate guilt by associating this malady with illness rather than with sin.

The crisis of illness and death of a family member, particularly that of a spouse is closely connected with Valium dependency. Frequently doctors, following the biased perception of women as emotionally weak, prescribe this drug to women at the time of a death. Bea recounts that she was so drugged she does not to this day remember anything about her husband's funeral. In a culture such as ours where grief is poorly understood, and mourning rituals impoverished, a woman experiencing normal grief is liable to think that she is becoming deranged. Her fear is validated by the doctor who prescribes a tranquilizer. Thus she is conditioned to repress her grief entirely. Three of the women whose stories are recounted in Chapter 2 carried a spiritual and emotional burden of unresolved grief.

The Sacrament of Anointing might be made more fruitful if the office of administering it were extended to persons who are immediately involved with the physical care and/or

counseling of the sick. Not all priests have the gifts or sufficient training for this ministry. If the sacrament is administered in a cold and perfunctory manner the outer sign belies the inner meaning and the person may be more deeply wounded rather than healed.

Sacramentals, Growth and Healing

In a lecture on holistic Religion Morton Kelsey remarked that the Catholic Church has an Aristotilian head and a Platonic Heart.[19] I would amend his statement and say that the Catholic Church has a masculinized head and a feminized heart. It was the wisdom of the feminized heart of the Church which created and preserved sacramentals.

Sacramentals were described in the old Catechism as "certain pious objects blessed by the church for the sanctification of those who use them." From that tradition we have blessed oil, blessed candles, blessed water, blessed beads, blessed medals. Some might call this superstition but I call it folk-religion. For deep in the consciousness of the people is the knowledge that all creation is at its core holy and powerfilled.

The blessing of the natural world may well be a remnant of that original matriarchal vision of the earth as

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[19]Morton Kelsey in a lecture delivered at the School of Theology Claremont, September 1981.

life-giving, nurturing and healing. The cult of the synthetic and the artificial, among other influences, has robbed us of our heritage of folk wisdom regarding health and healing. The cult of sacramentals in the Church points backwards and forwards. It points back to recall us to its meaning in the past and forward towards new ways of making that meaning vital in the future. Holistic medicine seems to be one area in which the blessedness of nature can be rediscovered and utilized.

Blessing has come in hierarchial theology to mean the calling down of a special power of grace upon a person or object. However, that is not the meaning of blessing in its primitive fundamental sense. It is rather the acknowledgement and affirmation of the goodness within a person, object, or action. Thus Elizabeth addressed Mary with a "Blessed is the fruit of your womb." Recovering from a kind of embarrassment at the accusation of superstition and from an attack of theological purity the contemporary church is re-discovering the power of blessings.

I believe that an expanded use of blessing would extend the notion of sacramentals to contemporary healing media--therapeutic technique, medical practices. In order to bless them, an adequately renewed and open church would as a community be called upon to assess the authenticity of the claims made by the specific medium. The church might exercise that charism in the realm of pastoral counseling by

discerning which insights from and techniques of the human sciences can really contribute to the total well-being of persons. With the rise of the specialist and the mystification of medicine and psychotherapy ordinary persons have abdicated the right to understand what is being done to their bodies or psyches. The deification of the specialist and a blind misplaced trust in the medical/psychiatric professions has contributed to the abuse in the prescribing and use of psychotropic drugs. Reclaiming the charism of blessing would restore to ordinary people the right to know what is and what isn't good for them and the power to choose accordingly. The refusal of the church to bless objects of destruction whether weapons, drugs or therapeutic techniques could be a salutary exercise of prophetic wisdom.

Ironically, the Church still blesses the corpse before burial, yet living bodies are seldom blessed as bodies. Women in the church could help to restore to one another a sense of bodily goodness by instituting blessings for significant times in their bodily lives, for instance at first menstruation, in pregnancy, in menopause.

Because of the extended life-span we now find ourselves in need of a sacrament for the crisis of middle age. Even without adding to the original seven it would be possible to institute a sacramental ritual to mark and sanctify this time of transition in human life. At this time the Church might incorporate into this ritual a time of preparation in

which middle aged persons would be helped to find spiritual meaning in their crisis of meaning and might be strengthened in their passage to a new phase of their lives.

Growth and Healing in Mysticism, Contemplation and Prayer

Another valuable resource in the Catholic Church is its traditional stream of mysticism. Unfortunately mystical theology has represented the mystical experience in abstract male terms. But the mystical experience is anything but abstract; it is an experience of the sacred core of reality, so dense and so concrete that it cannot be captured in the abstract symbolism of words. Mysticism involves an entering into what is contemplated in such a way that an intersubjective unity is attained and that unity is expressed affectively in love. Mystical knowledge is not abstract analytical knowing but caring, affective knowing. The Church has in true patriarchal fashion suspected mysticism because the experience of the mystic cannot be theologized into a controllable formula--the God of the mystic is too unutterably great. True mysticism has been said to be the special gift of the few. But mystical experience is a normal human event and would be enjoyed by more people if they were encouraged to let it happen. The Church has a treasure in its mystical tradition which might be shared by all.

Within the church are a body of women who have spent most of their lives learning the art of contemplative and mystical prayer. These women might minister to their sisters by passing on the art of contemplative prayer. It could even be taught to young children who have a natural affinity for wonder. Regular practice of such prayer would obviate the need for drugs to induce relaxation and to escape the tension and turmoil on the surface of reality, rather than enter into its still center. In particular, women who have been encultured to be attentive to and concerned about many things can easily fulfill their need to care for themselves by withdrawing for a time from preoccupation with external things and coming home to themselves.

Spiritual Direction and Women's Growth

Spiritual direction in the Catholic tradition has as its object guidance on the journey towards God. The characteristics which marked the style of a particular "school" of spiritual direction were shaped by several influences. One was the way in which God was perceived by the director and the tradition to which she/he belonged; another was the way in which the person being directed was perceived, and a third was the intellectual climate of the historical period in which the system of direction was operative. It would require a separate treatise to discuss fully the history and

development of Spiritual direction in the Catholic Church. That will not be attempted here. However it is important to note than the styles of direction which have been most dominant in the Church up until the present are models which have a strong patriarchal flavor. The Image of God has been male, the directee has been perceived as a subordinate, and the mode has been rational/intellectual. The history of the art abounds in male names Francis de Sales, Ignatius of Loyola, Thomas Merton.

However there is a different stream of spiritual direction in the Church which over the centuries has emerged from time to time and which is currently making a comeback. It is a tradition which incorporates more matriarchal traits. This is the mystical tradition. One of its great women exponents is Julian of Norwich a fourteenth century English mystic. Kenneth Leech calls her "the mystic of tenderness and naturalness in the approach to God."[20] She claimed that the simple intuition of God is within the possible experience of all. "Her central emphasis is one of cosmic optimism and the victory of God's love" says Leech. Julian is one of the first female theologians in the history of Christianity. Her perception of God as mother is a refreshing surprise in a discipline which has consistently imaged the ground of being as belonging to the dominant male sex.

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[20]Kenneth Leech, Soul Friend (San Francisco: Harper & Row, 1977), pp. 146-147.

In spiritual direction women have not been well-served in the church; in that they are in good company. Teresa of Avila had particular difficulty finding a suitable director. She says, "I could not find a director . . . who understood me though I looked for one for twenty years. . . ."[21]

Weaknesses in current spiritual direction which affect women are the unavailability of direction for most people, the male image of God and the male vision of holiness which informs most direction and the predominance of left-brain intellectual methods of prayer and ways of seeking the transcendent. These weaknesses might be ameliorated by a rediscovery of the mystical tradition of direction and a new application of the ancient Celtic tradition of soul-friend. In the Celtic church everyone was expected to have a soul-friend. St. Bridget is said to have stated that "Anyone without a soul-friend is like a body without a head."[22] The mystical tradition of spiritual guidance is a hidden treasure in the Church which needs to be unearthed and placed at the disposal of women. Joan, one of the women interviewed, was particularly insistent on her need for spirituality and her failure to find it in the church to which she belonged. Women, because they are so often forced

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[21]Teresa of Avila, Way of Perfection, quoted in ibid., p. 67.

[22]Ibid., p. 50.

to deal with the mystery in life--of birth and death of vulnerability and human finitude need more than periodic visits to a doctor or a counselor if they are not merely to solve problems, but to engage creatively in life at the level of its opacity and mystery.

Ministering to the Drug Dependent Woman

While a broad policy of change in attitudes, policies, and structures in the church, universal and local is a necessary backdrop for the unimpeded growth of women and consequently for the prevention of prescription-drug dependency, such a program will do little for the woman in the acute throes of that dependency. In fact preoccupation with the causes of the malady on the part of the dependent person and/or her helper can only serve to promote denial and divert attention from the proximate problem, the addiction and its immediate effects on herself and on her family. Ministry to her begins with efforts to identify the problem and to help her and her family acknowledge it.

If a priest or lay minister is approached by a woman who indicates that she is suffering from physical and/or emotional distress, tactful but firm inquiry should be made as to whether she is taking "medication" to help in coping with her pain. In order to illustrate a possible situation involving drug-dependency let us take up the little drama,

(mentioned in Chapter 3), of the woman who comes to the rectory door and asks to have a Mass said for her intentions. The woman's name is Maria, the priest is Father John.

Maria (looking nervous . . . hands shaking, eye contact shifting) Father, I want to . . . would you offer a Mass for some special intentions of mine?

Father John Certainly Maria, but come in while I get my appointment book . . . I need to take note of that (Father John shows her into his office and motions her to sit down) Now let me see . . . I could celebrate Mass for your intentions next Thursday? Could you and your family attend?

Maria I'll be there, Father and I'll bring the younger children but Jim (husband) . . . well you see he's part of the problem . . . he's been drinking a lot lately and well, what's happened is . . . our oldest daughter, you know she's sixteen, she got pregnant and when he heard about it he got mad . . . he'd been drinking a lot and . . . well he beat her up . . . she had a miscarriage . . . we took her to emergency and they took care of her . . . that was last week . . . she's all right now but . . . bursting into tears and sobbing . . . I think sometimes I can't stand it any longer . . . I've been having these terrible headaches.

Father John You have really been through an ordeal and I can see that you are still in a lot of pain . . . Have you been getting any support in dealing with all of these problems?

Maria Well, my doctor gave me some nerve pills when little Jimmy was born last year and then a month ago he gave me something to help me to sleep . . . with the baby and all this trouble I haven't been getting more than an hour or so . . . recently nothing seems to help . . . I am shaking all the time and sometimes I have these wierd sensations . . . I think I'm going crazy . . . Do you think I'm going crazy Father . . .! (more sobbing)

When Maria regains her composure Father John asks her if she knows the name of the "nerve pills" the doctor gave her and what she is taking to help her to sleep. She shows him a bottle of Valium and the label reads Valium 10 mgs. three times a day or as needed. She has been taking three or four a day for over a year. She is also taking seconol to help her sleep.

Father John Maria, did you know that these strange sensations you are experiencing could be the effects of the drugs you are taking?

Maria Oh no Father. My doctor told me they were quite safe so long as I followed the prescription.

Father John Well Maria, you have been taking a pretty high dosage over a long period of time and Valium has been found to cause symptoms like the ones you describe especially when mixed with other chemicals. I know a couple of doctors who have special training in evaluating medication. Would you be willing to see one of them to have your medication evaluated?

Maria It would be a relief if these feelings turned out to be just the pills, but I wouldn't want to offend Dr. Johnson by going to someone else.

Father John Maria, your well-being is more important than any doctor's feelings. Anyhow you have a perfect right to get a second opinion. The doctors I mentioned are Dr. Helen Stoner and Dr. Sam Vincent. If you agree to see one of them I would be glad to help you set up the appointment.

Maria Well, Father if you think I should, I'll go ahead and do it for I'm really at the end of my rope.

Maria is found to have a high level of Valium in her blood and she is admitted to an alcohol and drug dependency treatment center. The therapist at the center involves all of the family in the treatment and when Jim's alcoholism is discovered he is admitted to the outpatient program. Jim agrees to take antabuse but steadfastly refuses to go to AA, insisting that he can lick the problem with antabuse. Father John visits the unit occasionally to give Maria support in her treatment. During one of these visits he asks Maria if she would like to receive the sacrament of the sick. Maria is surprised and says "But Father I'm not sick; I'm a drug addict." Father John takes the opportunity to explain to her the nature of chemical dependency in terms of an illness which has affected her spiritually, emotionally as well as physically. He also helps her to explore feelings of guilt connected with the dependency. Maria agrees that she would like to receive the anointing of the sick. With her permission Father John asks a woman who is a minister of the Eucharist for the hospitalized to bring her communion after one of the Sunday masses. Receiving the Eucharist in connection with the Mass in her parish Church and being assured of the prayers of the Church gives her much consolation. She says that it helps her to feel a part of the church even though she cannot be present with the congregation.

While Maria is in hospital Father John visits with the family. He meets Jim and commends him for having taken

steps to deal with his alcoholism. In the course of the conversation Father John brings up the subject of AA and discovers that Jim attended one meeting at the hospital but that he felt out of place because most of the men there were professionals and he is a blue collar worker. Father John asks him if he would be willing to go to another meeting with a member of the parish who is an alcoholic and who, like Jim, is a truck driver. Jim agrees to give AA another try.

While Father John is in the home, Donna, the eldest daughter comes home from school. He tries to engage her in conversation but she answers sullenly and, as soon as she can escape, leaves. Father knows that she has been receiving counseling at the hospital but he is concerned about her possible sense of guilt and alienation from the church as well as the psychic damage caused by her father's abuse. He decides to ask the youth minister, a young woman with some training in counseling teenagers, to get in touch with Donna and try to befriend her. The youth minister invites Donna and her boy friend Dave to go on an outing with the youth group. They agreed to go and seem to enjoy the experience. Father John arranged through the youth minister to have a meeting with Donna and Dave to raise the question of how they were dealing with the possibility of another pregnancy should they continue to be sexually active.

Maria was discharged from hospital after being in the treatment program for six weeks. She continued to go back each afternoon to attend a group called, "pills anonymous." She also attended alanon a couple of times a week. With Father John's encouragement she worked out a system with Jim according to which he took care of the children in the evenings she went to alanon and she agreed to take care of them when he went to his AA meetings.

Six months later during the Lenten season a lay member of the parish invited Jim and Maria to take part in a weekend parish renewal. Though they were nervous about going they agreed when they heard that several other people they knew well were also attending. After a discussion on being reconciled with persons they had hurt or offended, Father John took an opportunity to ask Jim how things were between him and his daughter. Jim confessed that though he had apologized for what he had done, there was still great coldness and distance between them. Jim broke down and wept as he talked about the remorse he felt over the harm he had done his daughter. After the renewal weekend Maria dropped by the rectory to ask Father John to say a Mass in thanks-giving for her recovery from drug-dependency and for Jim's sobriety. Father John said that he would be happy to celebrate Mass in their home if they wanted him to. Maria was delighted with the suggestion and said that she would check with Jim and the children. Later she arranged for a

home Mass at which the entire family attended. The children had chosen the readings and some hymns they liked. During the penitential rite Father John invited anyone who wished to mention anything they were sorry they had done. Jim, in a very moving manner spoke of his anguish at what he had done to hurt his family while he was drinking and especially what he had done to Donna. Donna burst into tears and allowed her father to hug her and comfort her. Maria said that she was sorry for the bad example she had given the children in her abuse of pills.

As a result of her contact with other women during the parish renewal Maria began to attend a lay-led woman's spiritual growth group in the parish. Father John continues to check with the family from time to time to see how they are doing.

As a result of this experience with Maria Father John realized that there might be others in the parish who are dependent on various drugs or alcohol or who are compulsive over-eaters. He asked the leaders in the parish counsel to organize an Addiction Awareness Sunday with a view to providing information on the various forms of dependency and the help available to those afflicted or affected by them. On that Sunday the homilist, a priest who was a recovering alcoholic, spoke about his own experience with alcoholism. Persons recovering from dependencies volunteered to be available to answer questions after the Mass. After each Mass the

congregation was invited to view a choice of short movies on alcoholism, procure literature on various forms of dependency, and to talk to representatives from various hospitals and drug and alcohol treatment centers in the community. The entire program was planned and carried out by volunteers from various twelve step groups. Later in the year the adult education committee incorporated into its program several talks on drugs, legal and illegal and on various dependencies and recovery programs.

Effective ministry to the chemically dependent and their families requires that the pastor or minister of pastoral care be aware of the possibility of chemical dependency when there is conflict, crisis, or violence in a family. He should also be aware that a woman who has physical or emotional problems over a period of time is liable to be taking psychotropic drugs. It is important that the minister have knowledge of the resources available in the community: doctors who have experience with chemical dependency, hospital detox and rehabilitation programs, and, if possible, women on their staff who have knowledge of the special needs of women who are drug-dependent. Prescribed drug dependence, like alcoholism affects the entire family. It is therefore important that all be involved in a recovery program.

Steps in Recovery from Drug Dependency

1. Detoxification: This can take several weeks depending on the drug, the dosage and the length of time the person has been taking it. Because withdrawal symptoms may be severe and even life threatening this should be undertaken under medical supervision and may require hospitalization.

2. Medical Assessment: The drug-dependent woman should have a physical check-up to ascertain if there is any illness which may have preceded the drug-abuse and also to determine if the drug-abuse has affected her physically. She may need treatment for illnesses which if left untreated may precipitate the recurrence of the drug-abuse.

3. Therapy: This involves:

   A. Support therapy to help the person cope with depression, anxiety, and other emotional and physical withdrawal symptoms;

   B. Grief counseling to resolve grief over losses of various kinds;

   C. Therapy to help the drug dependent person cope with life without the drug.

4. Family Counseling: Frequently a drug problem in one or other member of a family is a symptom of other problems in the family system. Moreover, not only does the family need help in recovering from the effects of living with a drug-dependent parent they also need help in adjusting to the parents recovery which brings change into the family system.

5. Couple Counseling: Drug Dependency may have been a way of coping with marriage problems, such as communication problems, sex problems, rigid sex-roles, inequality in responsibility for parenting, infidelity, alcoholism or drug abuse on the part of the spouse.

6. Assertiveness Training: Drug-dependent women generally do not know how to get their needs met--they experience what Seligman calls learned helplessness. To counteract this programming they need extensive training in assertiveness.

7. Vocational Training: Women may need to re-enter the job market but do not know what they are suited for. They may need help in discovering their talents and, if they wish, to develop a career.

8. Health Education: Such education should be holistic in its thrust. The drug-dependent woman needs to understand the properties, the effects of and the use and abuse of chemical substances. She also needs education in ways to take care of her health through diet, exercise, relaxation, training in alternative forms of pain management, etc.

9. Spiritual Guidance: Issues such as guilt, crises of meaning, suffering, as well as spiritual growth experiences such as prayer and meditation are an important part of recovery.

10. On-going involvement in a self-help group: It is important that the self-help group be geared towards women's needs. Twelve-step programs have much to offer in support and spiritual growth. However, their male orientation needs to be modified somewhat to meet the needs of women. The woman's ego is fragile and needs to be built up. The rugged confrontation suited to macho-egos can be shattering for women.

In general women recovering from dependency on prescribed drugs do not identify with street drug addicts and do not profit from groups such as narcotics anonymous.

11. Involvement in Women's Conscious Raising and Growth Group: Women have need for experiences which will empower them to become more independent, economically self-supportive, and to develop strategies for effecting social change.

The following chart indicates appropriate intervention and ministry during the course of drug-dependency:

Course of Dependency

Progressive Steps	Intervention	Ministry
Stage I		
Normal Use: For short term medical crisis or emotional trauma	Ascertaining that the woman understands the hazards as well as the benefits of the drug, recommending alternative or additional ways of dealing with the problem for which the drug has been prescribed	Bring support of the Church--practical, emotional, sacramental (Example: grief counseling for the bereaved, involving other Church members in funeral and follow-up support; visiting in hospital in event of illness, bringing the Eucharist to the sick, providing help for the family in the case of serious illness, offering the prayers of the church community, praying with the sick person)

Progressive Steps	Intervention	Ministry
Stage II		
Dependency Stage:		
A. Needing drug periodically for serious but not traumatic life crises	Caring confrontation on her drug-abuse	Involving women in the parish who are recovering from drug-dependency in twelve-step work with her
B. Needing drug for minor crises	Referral to doctor/ counselor acquainted with a drug-dependency	Gentle confrontation with the real nature of her problem if the woman seeks help for personal or situational difficulties in the confessional or in spiritual direction
C. Needing drug to get through the day	Referral of spouse and family to Alanon and/or other self-help group for relatives of the chemically dependent	Nonjudgemental attitude--her problem is an illness, not a moral flaw
D. Running away--may leave the family without warning		
Stage III		
Despair Stage:		
A. Profound withdrawal from social contact	Procuring Crisis-counseling for spouse and family	Administration of the "last sacraments" in emergency room or elsewhere--opportunity to be supportive of the family and of the victim when she regains consciousness
B. Sleeping a lot--insomnia--anorexia	Helping family to have woman admitted to a drug-treatment facility	
C. Suicide attempts, child abuse	On-going contact and support of woman and family during treatment	Follow-up as in Stage II

Progressive Steps	Intervention	Ministry
Stage IV		
Recovery Stage:		
A. Detoxification		Reintegration of woman and family into Church Community life
B. Physical, psychological and spiritual rehabilitation		

Counseling the Drug-dependent Woman

Even though specialized pastoral counseling is not ordinarily a part of Catholic parish ministry, it is helpful for those engaged in pastoral care to know something of the elements involved in the counseling of drug-dependent women. For them and for those who may be engaged in specialized pastoral counseling I include here a description of the process. In the previous section I delineated ten steps in recovery which contain aspects which should be incorporated in an effective counseling program. However in this section I will spell out in greater detail elements which constitute many of these steps. I have chosen to incorporate them into a skills development approach to counseling recommended by Kerry G. Treasure and Helen Liao.[23] This approach seems

[23]Kerry G. Treasure and Helen Liao, "Survival Skills Training for Drug Dependent Women," in Breschner, II, 213-46.

particularly suited to drug dependent women because, in common with other women, but to an even greater extent, they suffer from a sense of powerlessness and low self-esteem. Empowerment towards self-sufficiency is particularly imperative in the recovery process.

Getting the Woman into Treatment

Before any counseling can take place it is necessary to do some difficult preliminary work in order to motivate the woman to accept treatment for her dependency. The first step in getting help for her is the counselor's recognition of the problem.[24] Rarely does a woman approach a pastoral counselor and say, "I have become dependent on prescribed drugs, help me." If she has recourse to a counselor at all it is more likely that she will complain of psychological symptoms such as anxiety or depression, a marriage or family problem, or a spiritual concern such as loss of faith or inability to pray. A typical conversation between a woman and a pastoral counselor might run as follows:

Woman — I don't know what has gotten into me lately, I just feel so down all the time. I just don't want to do anything around the house any more. I get so irritable with Hank (her husband) and I'm just not interested in sex or going out or doing anything. I think I have lost my faith and trust in God.

[24] See "Do You Have a Pill Problem" a leaflet test issued by Alcoholism Treatment Service, Pomona Valley Community Hospital, 1798 N. Gary Avenue, Pomona, CA 91767.

Counselor — Feeling so depressed and the way it's affecting your life and relationships is a real worry for you.

Woman — Yes, I'm down and then I worry about that and the arguments with Hank, and I'm ashamed to let anyone into the house it's such a mess. I don't go out, not even to Church and that just depresses me even more.

Counselor — Seems like you feel trapped in an endless cycle of depression.

Woman — Yes, like there's no way out . . . and there really is no reason for it now with the kids grown and out of the house and Hank such a good provider. You'd think I'd be happy now. It was different when Dave (her youngest child) was giving us all that trouble, running with that wild crowd and smoking marijuana. But the nerve pills the doctor gave me really helped me through that time. Lately they don't seem to help at all. Now Dave's away in college and doing well. I don't know why I'm so depressed. (starts to weep) I guess it's just middle-age blues as they say.

At this point the woman has presented the counselor with several areas to be explored. It would be tempting to conclude that her depression is related to the so-called "midlife crisis and the empty-nest syndrome." They may, indeed be very relevant to the woman's depression and warrant exploration at some point. However, like any other popular theory they may constitute a useful myth which enables both the woman and her counselor to avoid dealing with a more urgent problem, chemical dependency. Tucked into a conversation is also the reference to nerve pills prescribed to help the woman cope with her teenage son. I suggest that confronted with a choice of which of several issues to pursue, the

counselor give priority to the one that hints of possible drug dependency. Other issues can wait. The woman will not overdose on the "empty nest" but she may, while she and her counselor are engaging in prolonged discussions of this syndrome, overdose on the tranquilizer she has been receiving regularly from her doctor ever since she complained to him about the stress attendant on rearing the youngest of her children. Moreover, therapy aimed at relieving marital problems, sexual disfunction, communication problems, or just plain boredom will be ineffective so long as the woman is under the influence of chemicals.

In investigating whether the woman is still taking nerve pills what kind of pills they are and how long she has been taking them, it is best to avoid terms such as "addiction" or even "dependency." These have judgmental overtones and may merely serve to highten guilt and solidify denial. A less threatening approach is to deal initially with the physiological effects of prolonged use of psychotrophic drugs in an objective and informative manner and to suggest that these drugs have properties which may, if they are used over a prolonged period, cause depression. The aim here is to have the woman consent to having her medication evaluated by a doctor competent in the area of prescribed drug dependency. In this instance "medicalizing" the problem is a valid approach because the problem is in part medical, and recovery must

involve medical supervision especially during the initial withdrawal stages.

As is the case with alcoholism, the counselor should expect that the woman is immeshed in a complex network of denial. Try as she may it may be impossible for the counselor to get behind her defensive wall. There is a theory in the treatment of alcoholism that a person has to "hit bottom" before being ready to take steps towards recovery. There is a certain validity to this theory. However, it is no longer believed that the person needs to have reached the last stages of the disease before "bottoming out." The aim now is to "raise the bottom," that is, to enable the person to experience the consequence of her or his dependency as early as possible in the course of the disease in order to facilitate a crisis which forces the person to seek help. The same principle holds for the person dependent on prescribed drugs. It is important, therefore, to involve the family of the woman as well as other significant persons from the very beginning of the counseling process and that, not only to enlist their help, but because they too have been affected by the dependency are probably unconsciously facilitating it and need help themselves.

In I'll Quit Tomorrow, Vernon E. Johnson describes one method of intervention in which the family and friends of the chemically dependent person are, with the help of a counselor, facilitated in a group session during which they

in a firm and caring way confront the afflicted person with the effect her/his disease is having on all concerned.[25] Explaining the necessity of intervention Johnson says that because of the ravages of the disease the chemically dependent person's perception of reality is often too distorted for her/him to make realistic judgments. What Johnson says of alcoholism can be applied with equal validity to any chemical dependency. He states that there are two obstacles which prevent recovery. The first is that those involved with the person do not understand the person's condition, are cut off because of the person's behavior, and respond with blame or withdraw in the fond hope that she/he will one day have a spontaneous insight. The second reason is that the person refuses help because of rigid defenses and a distorted memory pattern. Johnson concludes:

> It is quite obvious that his (sic) condition requires intervention <u>from the outside</u>, and it is equally obvious that only more knowledgeable persons on the outside will be able to perform this function.26

Chemically dependent persons who work outside the home can frequently be reached through and by employers and supervisors, especially if their dependency is impairing

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[25]Vernon Johnson, <u>I'll Quit Tomorrow</u> (New York: Harper & Row), pp. 44-51.

[26]Ibid., p. 44.

their work performance and putting their job in jeopardy. However, many women who are dependent on prescribed drugs do not work outside the home, thus the main possibilities for intervention are within the immediate family who are frequently a major part of the denial system. In this case it is important that the pastoral counseling be directed towards the family. The initial aim should be to persuade the family that they need help themselves and to direct them into a self-help or other program for the families of the chemically dependent. If the family begins to recover, the chances of recovery for the dependent person are increased. In this regard the pastoral counselor in a parish has a special advantage because of the access to the family which her/his role in pastoral care permits. In the parish setting it is also possible for intervention to be initiated through the teachers of the children in the afflicted family or through women friends in parish guilds, Bible study groups, or other church organizations. The progress of the disease will be detectable in child neglect or abuse which may come to the notice of teachers, or in progressive withdrawal from social contact which will result in the woman's absence from church-related activities. Regarding school personnel as a possible intervention resource Michael Leipman, et al. state:

> School personnel and other child-related service providers often become aware of drug-dependency problems through their family contacts . . . and could apply pressure to motivate the family to seek help. However,

> many school staff feel that parental drug problems are outside of their scope of responsibility. They also have little or no training on ways to respond to such problems. Yet, concern for their children is a primary reason women say they seek treatment for drug dependency . . . This fact suggests that with appropriate training, teachers and other childcare workers might be particularly potent motivators and referral resources.27

I might add that the pastoral counselor in a parish is the ideal person to provide that training.

Many women will never become sufficiently self-motivated to seek treatment for their drug dependency. Moreover, coersive tactics such as those used by employers through employee assistance programs or by the courts through threat of legal action for drug-related infringements of the law can seldom be applied to women dependent on prescription drugs. Leipman et al. make important distinction between men and women in the effectiveness of coercive methods.

> Some gender - specific differences in social surroundings affect the applicability of existing coercive programs and forces. Men are more often forced to seek treatment by spouses, employers, and the legal system, whereas women tend to be encountered by medical care and child-oriented systems. . . . Drug dependent women are less likely than men to have spouses or partners, and those who do, often have partners who are dependent on drugs. Thus, pressure from a spouse or partner to enter treatment is less likely to occur for drug-dependent women than for men.28

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[27]Michael R. Leipman et al., "An Ecological Approach for Motivating Women to Accept Treatment for Drug Dependency," in Bresdiler, II, 4.

[28]Ibid., II, 3.

On the positive side, it has been found that drug-dependent women are more likely to enter treatment so long as they are not protected by others and have access to an attractive treatment program.[29] Moreover, women tend to be more responsive than men to the reactions of significant persons in their lives. These facts make the role of the pastoral counselor, who is often a significant person to the church-affiliated woman pivotal in inducing her to enter treatment and in bridging between her, her family and the treatment center.

Once the pastoral counselor has successfully referred the woman to a treatment center her/his work is not over. Ideally the counselor should be involved in the treatment and where possible participate actively with the woman and her family in the program. The pastoral counselor should supply either during or after hospital treatment elements essential to recovery which may be omitted from or inadvertently covered in the treatment program. The following is a list of issues significant in the recovery of drug-dependent women, some or all of which may not be handled in a hospital program.

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[29]Ibid., II, 4.

Developing Survival Skills

Kerry Treasure and Helen Liao in "Survival Training for Drug Dependent Women" say:

> For many women seeking treatment, drug dependency is simply the most obvious and painful manifestation of the larger female condition: socially encouraged dependency. It follows then, that effective treatment must attack not only the drugs in a woman's life, but the dependency that dominates it.30

These authors divide survival skills into two categories, "being skills" and "doing skills." Being skills include skills in self development, interpersonal skills and social relationship skills.

Self-development. These skills include ways of improving the woman's self-image by, for instance, lowering impossible performance expectations and setting for herself short-range and attainable goals. They also involve exploration of her own personal values as distinct from those which have been imposed upon her by stereotypical cultural norms, learning about and accepting her body, learning stress-management techniques exploring the creative arts and discovering and developing her own creative talents. I would add to these exploring and developing a spirituality which is liberating and self-affirming.

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[30]Treasure and Liao, II, 137.

Sexuality and sexual concerns are particularly relevant to the drug-dependent woman. In a study by Wasnick et al., eighty-six percent of the thirty-six drug-dependent women interviewed stated that counselors never treated of these concerns.[31] Because of the myths and stereotypes surrounding woman's sexuality it is important that the counselor be well informed and sensitive to women's sexual issues. Otherwise he/she should refer the woman to a competent counselor.

Interpersonal Skills. Among these, Treasure and Liao list the following: giving and receiving feedback, being assertive, listening and speaking, being empathetic, expressing anger and managing conflict. Women need help in dealing with social attitudes towards women being assertive and be prepared to deal with them.[32] In particular the drug-dependent woman will have to deal with negative reactions towards the changes which take place as she recovers and is no longer sedated and compliant.

Social Relationship Skills. The recovering drug-dependent woman needs to develop nurturing social relationships if she is to remain drug-free. For her, social inter-

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[31]Joselle Mondamaro et al., "Sexuality and Fear of Intimacy as Barriers to Recovery for Drug Dependent Women," in Beschner, II, 304.

[32]Treasure and Liao, II, 142.

action will be particularly difficult, since she has for a major part of her life been isolated from others. Important skills in this area are making friends, forming and maintaining an intimate relationship, learning mutuality in a relationship, and learning how to participate in and lead a group.[33]

Doing Skills

Many women become and remain dependent on others, particularly on males because they lack basic skills necessary for survival. Treasure and Liao divide these skills into eight categories: Economics, housing, health, transportation, homemaking, household, legal and parenting skills.

Economics. There is a whole range of skills required in getting and keeping a job, asking for a raise, handling sexual harassment on the job, obtaining job training, working with the welfare system and obtaining necessary child care. These should be a significant part of an effective counseling program. In addition to these skills there are also important financial management skills necessary. These include banking, making and following a budget, obtaining loans, obtaining good insurance coverage, establishing credit, filling out income tax forms.

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[33]Ibid.

Housing. In order to obtain housing, women need to know how to read and understand a lease, how to apply for subsidized housing, how to choose housing in consideration of rent security, utilities, location, security, etc.

Health. Drug-dependent women have more health problems than other women. In many cases mismanagement in relationship to health contributed to their drug-dependence. They need to understand basic nutrition, how to obtain medical services from doctors and in environments sensitive to women's issues and to the special needs of drug-dependent persons. They need to understand and have enough information to make responsible decisions about birth control, how to render first aid and treat minor illnesses, and how to maintain physical fitness through suitable exercise.

Transportation. This is an area in which women are often exploited. It is therefore important for them to know how to choose and finance an automobile, how to do basic maintenance, how to take a driving test, and how to insure and register a car.

Homemaking. This may well be the one area in which a woman feels competent. However it is important not to assume that she possesses the homemaking skills that she needs, especially how to shop economically.

Household. An area in which she may not be at all skilled is that of doing basic household repairs such as minor plumbing, electrical repairs, furniture refinishing. If she shares a home with a male it is important that she know how to negotiate a fair division of the homemaking tasks.

Legal. Drug-dependent women may have occasion to deal with the legal system. They need to know enough to demystify it so that they do not feel overpowered and victimized. It is important that they know how to prepare a will, how to obtain a divorce, how to obtain child custody, how to report rape or other assault.

Parenting Skills. Frequently women are first introduced to prescribed drugs at a time of family crisis arising out of parent-child conflict. A parenting program should deal with feelings of guilt and worthlessness arising from child-neglect which occurred during the acute drug-dependency period. It should where relevant acquaint the woman of child day care facilities. For the single or divorced mother it should deal with child support and visitation rights issues.[34]

Obviously this program is so comprehensive that it would be impossible for one counselor to handle it all. The

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[34]Ibid. II, 142-144.

pastoral counselor should, therefore be acquainted with auxiliary resources within the local community to which she/he may refer the woman for specialized skills training. Moreover, a careful screening of the skills which the woman already possesses will free the counselor to concentrate on areas of skill deficiency and thus diminish the task.

Always, in the counseling relationship, the counselor needs to be aware that the woman's major need is to be empowered to become self-reliant. Otherwise, she may simply be induced to transfer her dependency on drugs to dependency on the counselor. This is particularly a hazard in the Catholic parochial environment where women are still conditioned to idolize pastors and other church authority figures.

Conclusion

The response which I have described in the foregoing pages is geared to what I consider a moderately progressive parish within the present Catholic Church system. It does not delineate what I would consider the ideal, if not yet attainable, milieu which would potentiate growth in women and render the need for recourse to psychotrophic drugs rare. Such a Church would both model and promulgate the full equality of women and men. It would admit to ordination and to all ministerial offices both men and women, married and celebate. In this way not only would the ministerial

vocation of all be encouraged but men and women from various life-styles would have available a sacramental ministry from persons who could best understand their experience, life-style and needs.

In such a Church, compassion and justice would both inform the formulation and the application of law. Members of such a church would be aware of themselves as at once both holy and flawed and this awareness would make possible an environment in which it would be possible to admit failure without loss of self-esteem and with assurance of acceptance and encouragement as well as challenge. Such a church would be dedicated to nurturing its members towards a fuller life rather than programming and controlling them.

Theologians in such a church would explore and integrate into its scriptural hermeneutics and its beliefs and practices the wisdom of godess religions. Behind the moral code of such a church would lie the affirmation of life in all its manifestations and the blessing of all that nurtures, heals and reconciles people. It would eliminate from its language, imagery and rituals everything which indicates patriarchal bias, affirming through an inclusive language and varied symbolic system both male and female.

On the practical side, a parish in such a system would have on its staff one or more trained pastoral counselors whose major role would be to train individuals and groups in skills necessary for mutual ministry and to

empower people to find and utilize the resources both spiritual and material which they need. Their aim would be to render themselves dispensible by eliminating hierarchial professionalism and demystifying both the theological and the psychological disciplines, creating thereby an environment in which there is a variety but not a hierarchy of gifts.

I do not expect that even with a maximum of good will this ideal will be immediately or soon attainable. However, I expect a genuinely renewed church to explicitly endorse this ideal as its goal and, while working towards it, critique its on-going progress in light of it. Such a church would merit the right and exercise the power to be prophetic in its demand for an end to all forms of discrimination and oppression in the world.

Looking realistically at many parishes I know that not only is the ideal not even remotely entertained, but even the moderate possibilities of Vatican II have not yet been actualized to any significant extent. What then is the minimum that is possible in such a milieu? In the strictly traditional structure there is not a total absence of concern for the suffering, though that concern is often expressed in a somewhat patronizing way, described in terms of charity rather than of justice. In such a church I would hope for the recognition that human problems are the concern of the Church. I would expect that those who exercise ministry would become acquainted with the nature of dependency on

prescribed drug in women and would refer those affected to competent treatment centers and/or counselors. I would ask that the problem be recognized as a disease which evokes compassion rather than a moral flaw which merits condemnation. I would recommend that existing structures be used to educate people in the uses, misuses and hazards of prescribed drugs.

Responding to prescribed drug dependency as a symptom of a disordered culture, and an autonomous disease with physical, psychological, interpersonal and spiritual implications calls the Catholic Church to become what it has been traditionally named, "Our holy Mother." If answered, this call would ultimately bring about the rediscovery and restoration of the visions and values of matriarchy which when wedded to whatever is wholesome in patriarchy might bring forth a church in which as Elisabeth Schussler Fiorenza says:

> . . . Women and men are able to live in nonsexist Christian communities, to celebrate nonsexist liturgies, and to think in nonsexist theological terms and imagery . . .35

Such a Church might then have the power and the vision to begin the transformation and renewal of the world. Finally I would demand that the limited possibilities for the involvement of women in the ministerial and decision making

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[35]Elisabeth Schussler Fiorenza, "Feminist Spirituality, Christian Identity, and Catholic Vision," in Carol P. Christ and Judith Palskow (eds.) Womanspirit Rising (San Francisco: Harper & Row, 1979), p. 147.

processes of the Church afforded by Vatican II be made a goal, and implementation be begun. Any church which takes seriously its call to preach the good news and to minister effectively cannot long remain static; its very efforts to respond to suffering humanity will automatically effect change.

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